TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH OF PLANO

Respondent Name
HARTFORD CASUALTY INSURANCE COMPANY

MFDR Tracking Number
M4-19-0175-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
September 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Physical therapy services have not been reimbursed per state fee schedule rules."

Amount in Dispute: $122.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services were processed in accordance with Texas Guidelines, 134.403."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
June 13, 2018 to June 29, 2018	Outpatient Facility Physical Therapy	$122.16	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
4. Texas Labor Code §408.021 entitles an injured employee to all required health care as and when needed.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 119 – BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
   - 163 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE UNIT VALUE AND/OR MULTIPLE PROCEDURE RULES
   - 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
   - 243 – THE CHARGE FOR THIS PROCEDURE WAS NOT PAID SINCE THE VALUE OF THIS PROCEDURE IS INCLUDED/BUNDLED WITHIN THE VALUE OF ANOTHER PROCEDURE PERFORMED.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 1115 - WE FIND THE ORIGINAL REVIEW TO BE ACCURATE AND ARE UNABLE TO RECOMMEND ANY ADDITIONAL ALLOWANCE

Issues

1. Are the disputed services or the injured employee subject to a benefit maximum?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code "119 – BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED."

   Texas Labor Code §408.021(a) provides that "An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed."

   The insurance carrier did not present any information to support a "benefit maximum" applicable to the disputed services. This denial reason is not supported. These services will be reviewed for reimbursement in accordance with division rules and fee guidelines.

2. This dispute regards physical therapy services performed in an outpatient facility. Such services are not paid under Medicare's Outpatient Prospective Payment System but using Medicare's Physician Fee Schedule. Per DWC's *Hospital Facility Fee Guideline*, Rule §134.403(h), if Medicare reimburses using other fee schedules, DWC guidelines applicable to the code on the date provided are used for payment. DWC *Medical Fee Guideline for Professional Services*, Rule §134.203(c), requires the maximum allowable reimbursement (MAR) be determined by applying Medicare payment policies modified by DWC rules. The Medicare fee is the sum of the geographically-adjusted work, practice expense and malpractice values multiplied by a conversion factor. We substitute DWC's conversion factor to calculate the MAR. The 2018 DWC conversion factor is $58.31.

   Per Medicare payment policy, when more than one unit is billed of therapy services with multiple procedure payment indicator '5', the first unit of the therapy with the highest practice expense for that day is paid in full. Payment is reduced by 50% of the practice expense (PE) for each extra therapy unit performed on that date.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 97010 (billed for dates of service June 13, June 15, June 18, June 20, June 22, June 25, and June 29, 2018) has status indicator B, denoting bundled codes. Reimbursement is included with payment for other services billed on the same day to which this code is incident. This code is not paid separately.
   - Procedure code 97110, June 13, 2018, has a Work RVU of 0.45 multiplied by the Work GPCI of 1 is 0.45. The practice expense RVU of 0.4 multiplied by the PE GPCI of 0.938 is 0.3752. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.796 is 0.01592. The sum is 0.84112 multiplied by the DWC conversion factor of $58.31 for a MAR of $49.05. For each extra therapy unit after the first unit of the code with the highest practice expense for that date, payment is reduced by 50% of the practice expense. This code has the highest PE for this date. The first unit is paid at $49.05. The PE reduced rate is $38.11. The total for 2 units is $87.16.
   - Procedure code 97110, June 15, 2018, the total for these 2 units is also $87.16.
   - Procedure code 97110, June 18, 2018, the total for these 2 units is also $87.16.
   - Procedure code 97110, June 20, 2018, the total for these 2 units is also $87.16.
   - Procedure code 97110, June 22, 2018, the total for these 2 units is also $87.16.
   - Procedure code 97110, June 25, 2018, the total for these 2 units is also $87.16.
   - Procedure code 97110, June 27, 2018, the total for these 2 units is also $87.16.
   - Procedure code 97110, June 29, 2018, the total for these 2 units is also $87.16.
   - Procedure code 97140, June 13, 2018, has a Work RVU of 0.43 multiplied by the Work GPCI of 1 is 0.43. The practice expense RVU of 0.35 multiplied by the PE GPCI of 0.938 is 0.3283. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.796 is 0.00796. The sum is 0.76626 multiplied by the DWC conversion factor of $58.31 for a MAR of $44.68. For each extra therapy unit after the first unit of the code with the highest practice expense for that date, payment is reduced by 50% of the practice expense. The PE for this code is not the highest. The PE reduced rate for 1 unit is $35.11.

- Procedure code 97140, June 15, 2018, reimbursement for 1 unit for this date is also $35.11.
- Procedure code 97140, June 18, 2018, reimbursement for 1 unit for this date is also $35.11.
- Procedure code 97140, June 20, 2018, reimbursement for 1 unit for this date is also $35.11.
- Procedure code 97140, June 22, 2018, reimbursement for 1 unit for this date is also $35.11.
- Procedure code 97140, June 25, 2018, reimbursement for 1 unit for this date is also $35.11.
- Procedure code 97140, June 27, 2018, reimbursement for 1 unit for this date is also $35.11.
- Procedure code 97140, June 29, 2018, reimbursement for 1 unit for this date is also $35.11.

3. The total allowable reimbursement for the disputed services is $978.16. The insurance carrier paid $978.24. The amount due is $0.00. No additional payment is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	October 12, 2018
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307.

A party seeking review must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M) in accordance with the form's instructions. The division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Include a copy of this *Medical Fee Dispute Resolution Findings and Decision*** together with any other information required by 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.