



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

TEXAS HEALTH OF PLANO

Respondent Name

GREAT DIVIDE INSURANCE COMPANY

MFDR Tracking Number

M4-19-0664-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

October 5, 2018

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: \$96.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see enclosed copies of medical fee dispute resolution Request, Re-Eval EOR and TX FS State Review on PT services. Dates of service 01/02/18 through 01/12/18."

Response Submitted by: Berkeley Entertainment

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 2, 2018 to January 12, 2018	Outpatient Hospital Physical Therapy	\$96.93	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
- 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 231 – MUTUALLY EXCLUSIVE PROCEDURES CANNOT BE DONE ON THE SAME DAY/SETTING.
 - 246 – THIS NON-PAYABLE CODE IS FOR REQUIRED REPORTING ONLY.
 - 356 – THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS THE TEXAS MARKUP.
 - 434 – THIS PROCEDURE CODE IS NOT REIMBURSED WHEN BILLED WITH ANOTHER MUTUALLY EXCLUSIVE PROCEDURE CODE ON THE SAME DATE OF SERVICE.
 - 652 – THIS PROCEDURE CODE IS USED FOR REPORTING PURPOSES ONLY. NO PAYMENT IS DUE.
 - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
 - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
 - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issue

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards physical therapy services performed in an outpatient facility. Such services are not paid under Medicare's Outpatient Prospective Payment System (OPPS) 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, services are paid using DWC guidelines applicable to the code on the date provided. *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 MAR is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the 2018 DWC conversion factor of \$58.31.

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

Reimbursement is calculated as follows:

- Procedure code 97110, January 2, January 3, January 4, January 5, January 8, January 9, January 10, and January 12, 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 PE, payment is reduced by 50% of the practice expense. The PE for this code is not the highest. The PE reduced rate is \$38.11 at 1 unit each for 8 dates of service results in a MAR of \$304.88
- Procedure code 97112, January 2, January 3, January 4, January 5, January 8, January 9, January 10, and January 12, 2018, has a Work RVU of 0.5 multiplied by the Work GPCI of 1 is 0.5. The practice expense RVU of 0.47 multiplied by the PE GPCI of 0.938 is 0.44086. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.796 is 0.01592. The sum is 0.95678 multiplied by the DWC conversion factor of \$58.31 for a MAR of \$55.79. For each extra therapy unit after the first unit of the code with the highest PE, payment is reduced by 50% of the practice expense. This code has the highest PE. The first unit is paid at \$55.79 at 1 unit each for 8 dates of service results in a MAR of \$446.32
- Procedure code 97140, January 2, January 3, January 4, January 5, January 8, January 9, January 10, and January 12, 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 PE, payment is reduced by 50% of the practice expense. The PE for this code is not the highest. The PE reduced rate is \$35.11 at 1 unit each for 8 dates of service results in a MAR of \$280.88
- Per Medicare policy regarding Correct Coding Initiative (CCI) edits, procedure code 97530, January 3, 2018, may not be reported with code 97140 billed on the same day. A modifier may be used to justify separate payment if supported by medical records; however, review of the submitted medical bill finds no appropriate modifier appended to code 97530. Nor did the provider explain or justify how the services were separate. Consequently, payment for this service is included in the reimbursement for primary code 97140. Separate payment is not recommended.
- Procedure codes G8978, G8979, and G8980 have status indicator Q, denoting functional information codes used for reporting purposes only. No separate payment is made.

The total allowable reimbursement for the disputed services is \$1,032.08. The insurance carrier paid \$1,196.16. 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 emphasizes that the findings in this decision 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	November 20, 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 DWCO45M) 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.