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 FORT WORTH

Respondent Name
TRAVELERS INDEMNITY COMPANY

MFDR Tracking Number
M4-19-2394-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
December 31, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "An authorization was obtained on 05/31/2018 … valid from 05/31 to 08/31/2018."

Amount in Dispute: $60.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the Provider was properly reimbursed per the Medicare edits and the Division's Maximum Allowable Reimbursement."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
June 7, 2018 to June 29, 2018	Hospital Outpatient Physical Therapy	$60.30	$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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 119 – BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
   - 152 – NO MORE THAN FOUR PHSYICAL MEDICINE PROCEDURE OR MODALITY CODES ARE REIMBURSABLE DURING THE SAME VISIT WITHOUT PRIOR AUTHORIZATION.
   - 947 – UPHELD. NO ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED
   - 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
   - 163 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE UNIT VALUE AND/OR MULTIPLE PROCEDURE RULES

Issues

1. Did the injured employee exceed a benefit maximum for any time period or occurrence?
2. 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
   - 152 – NO MORE THAN FOUR PHSYICAL MEDICINE PROCEDURE OR MODALITY CODES ARE REIMBURSABLE DURING THE SAME VISIT WITHOUT PRIOR AUTHORIZATION.

   Texas Labor Code §408.021(a) guarantees 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 that the injured employee's benefits are subject to a benefit maximum, or that such a maximum was exceeded. Nor did the carrier support that no more than four physical medicine procedure codes or modality codes are reimbursable during the same visit without prior authorization. These denial reason are not supported. The services will therefore 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 (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 DWC annual conversion factor.

   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, June 7, June 12, June 14, June 20, June 25, 2018, June 29, 2018, has a Work RVU of 0.45 multiplied by the Work GPCI of 1.007 is 0.45315. The practice expense RVU of 0.4 multiplied by the PE GPCI of 0.986 is 0.3944. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.747 is 0.01494. The sum is 0.86249 multiplied by the DWC conversion factor of $58.31 for a MAR of $50.29. 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 $50.29; for 6 visits the total is $301.74.
   - Procedure code 97140, June 7, June 12, June 14, June 20, June 25, 2018, June 29, 2018, has a Work RVU of 0.43 multiplied by the Work GPCI of 1.007 is 0.43301. The practice expense RVU of 0.35 multiplied by the PE GPCI of 0.986 is 0.3451. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.747 is 0.00747. The sum is 0.78558 multiplied by the DWC conversion factor of $58.31 for a MAR of $45.81. 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 $35.75; for 6 visits the total is 214.50.

   The total allowable reimbursement for the disputed services is $516.24. The insurance carrier paid $516.24. The amount due is $0.00. No additional payment is recommended.

Conclusion

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 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $0.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	January 25, 2019
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.