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 ARLINGTON

Respondent Name

HARTFORD CASUALTY INSURANCE COMPANY

MFDR Tracking Number

M4-19-2666-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

January 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/Denied Physical Therapy Rate …"

Amount in Dispute: $30.15

RESPONDENT'S POSITION SUMMARY

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

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 6, 2018 to September 27, 2018	Outpatient Hospital – Physical Therapy: 97140	$30.15	$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:
    - 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.
    - 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. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 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 (OPPS) but instead use Medicare's Physician Fee Schedule. DWC *Hospital Facility Fee Guideline*, Rule §134.403(h), requires that 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 97140 (performed September 6, September 13, and September 27, 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 billed for these dates. The PE reduced rate is $35.75. This amount multiplied by 3 days is $107.25.

   The total allowable reimbursement for the disputed services is $107.25. The insurance carrier paid $35.75 for 3 visits for a total of $107.25. The amount remaining 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, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	February 15, 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.