



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

M4-19-3362-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

March 4, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid Therapy Rate."

Amount in Dispute: \$45.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Disallow Modality (97010-97039) codes not billed with PT codes (97110-97799)."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 2, 2018 to August 8, 2018	Physical Therapy: 97110, 97140, G0283	\$45.77	\$17.62

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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.
- Texas Labor Code §408.021 entitles an injured employee to all required health care as and when needed.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 107 – CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT PREVIOUSLY PAID OR IDENTIFIED ON THIS CLAIM.
 - 246 – THIS PROCEDURE IS INAPPROPRIATELY BILLED. IT SHOULD ONLY BE BILLED IN CONJUNCTION WITH APPROPRIATE REQUIRED CODE.
 - 119 – BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
 - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
 - 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.
 - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
 - 1115 - WE FIND THE ORIGINAL REVIEW TO BE ACCURATE AND ARE UNABLE TO RECOMMEND ANY ADDITIONAL ALLOWANCE
 - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

1. Is 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

While the division has adopted Medicare *payment* policies in administering the workers' compensation medical fee guidelines, it has not adopted Medicare's *benefit* limitations. Texas Labor Code §408.021(a) entitles injured employees "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 or the disputed services were subject to a "benefit maximum." This denial reason is not supported. The services will therefore be reviewed for reimbursement in accordance with division rules and fee guidelines.

2. The insurance carrier denied therapy code G0283 (electrical stimulation) with claim adjustment reason code:

- 107 – CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT PREVIOUSLY PAID OR IDENTIFIED ON THIS CLAIM.
- 246 – THIS PROCEDURE IS INAPPROPRIATELY BILLED. IT SHOULD ONLY BE BILLED IN CONJUNCTION WITH APPROPRIATE REQUIRED CODE.

In support of these denial reasons, the respondent's position statement asserts, "Disallow Modality (97010-97039) codes not billed with PT codes (97110-97799)."

DWC *Professional Medical Services Fee Guideline* Rule §134.203(b)(1) requires for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply "Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; ... and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The respondent presented no information to support that Medicare payment policy requires code G0283 to be billed with a qualifying service or additional required code. These denial reasons are not supported. The disputed service will therefore be reviewed for payment in accordance with division rules and fee guidelines.

3. This dispute regards outpatient physical therapy services that 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 G0283, August 2, 2018, has a Work RVU of 0.18 multiplied by the Work GPCI of 1.007 is 0.18126. The practice expense RVU of 0.23 multiplied by the PE GPCI of 0.986 is 0.22678. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.747 is 0.00747. The sum is 0.41551 multiplied by the DWC conversion factor of \$58.31 for a MAR of \$24.23. For each extra therapy unit after the first unit of the code with the highest PE for each day, payment is reduced by 50% of the practice expense. The PE for this code is not the highest. The PE reduced rate is \$17.62. The insurance carrier paid \$0.00. The recommended payment is \$17.62.

- Procedure code 97110, August 6, 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. The PE for this code is not the highest. The PE reduced rate is \$38.79 at 2 units is \$77.58. The insurance carrier paid \$77.58. No additional payment is recommended.
- Procedure code 97140, August 8, 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. The insurance carrier paid \$35.75. No additional payment is recommended.

The total MAR (maximum allowable reimbursement) for the services in dispute is \$130.95. The insurance carrier has previously paid \$113.33. The amount due to the requestor is \$17.62. This amount 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 the findings in this decision are based on the available evidence presented by the requestor and respondent up to 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 established that additional reimbursement is due. As a result, the amount ordered is \$17.62.

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 \$17.62, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	March 29, 2019 Date
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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 prefiera hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.