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
KELLER INDEPENDENT SCHOOL DISTRICT

MFDR Tracking Number
M4-19-3701-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
April 5, 2019

Response Submitted By
No response submitted for review

REQUESTOR'S POSITION SUMMARY

[The requestor did not submit a position statement for consideration in this review.]

RESPONDENT'S POSITION SUMMARY

[The insurance carrier did not submit a response for consideration in this review.}

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 1, 2018 to May 29, 2018	Physical, Occupational, Speech & Psych. Therapy	$886.44	$0.00

AUTHORITY

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

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 division provided a copy of the Medical Fee Dispute Resolution request to the insurance carrier's Austin representative, receipt acknowledged April 12, 2019. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier has not responded. Consequently, this decision is based on the information available at the time of review.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
   - P14 – The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.

- 231 – MUTUALLY EXCLUSIVE PROCEDURES CANNOT BE DONE ON THE SAME DAY/SETTING.
- W3 – REPORTING PURPOSES ONLY.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

<u>Issues</u>

Is the requestor entitled to additional reimbursement?

<u>Findings</u>

This dispute regards outpatient therapy services not paid under Medicare's Outpatient Prospective Payment System but using Medicare's Physician Fee Schedule. DWC *Hospital Fee Guideline* Rule §134.403(h) requires use of the fee guideline applicable to the code on the date provided if Medicare reimburses using other fee schedules. DWC *Professional Fee Guideline* 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 a DWC 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:

- Per Medicare policy regarding correct coding (CCI edits), procedure code 97110 (May 1, May 2, and May 8, 2018) may not be reported with speech therapy code 92507 billed for these same dates. Payment is not recommended.
- Procedure code 97110 (May 10, May 15, May 17, May 24, May 29, and May 31, 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. The PE reduced rate is $38.79 at 3 units is $116.37. The total is $166.66, for 6 visits is $999.96.
- Procedure code 97110 (May 10, 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 4 units is $155.16.
- Procedure code 92507 (May 1, May 2, and May 8, 2018) has a Work RVU of 1.3 multiplied by the Work GPCI of 1.007 is 1.3091. The practice expense RVU of 0.87 multiplied by the PE GPCI of 0.986 is 0.85782. The malpractice RVU of 0.05 multiplied by the malpractice GPCI of 0.747 is 0.03735. The sum is 2.20427 multiplied by the DWC conversion factor of $58.31 for a MAR of $128.53. This code has the highest PE for these dates. The first unit is paid at $128.53, for 3 visits totals $385.59.
- Procedure code 96152 (May 29, 2018) has a Work RVU of 0.46 multiplied by the Work GPCI of 1.007 is 0.46322. The practice expense RVU of 0.07 multiplied by the PE GPCI of 0.986 is 0.06902. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.747 is 0.01494. The sum is 0.54718 multiplied by the DWC conversion factor of $58.31 for a MAR of $31.91 at 4 units is $127.64.

The total allowable reimbursement for the disputed services is $1,668.35. The insurance carrier paid $1,886.53. 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 findings in this decision are based on the evidence 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

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

______________________	Grayson Richardson	May 17, 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.