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 FLOWER MOUND

Respondent Name
HARTFORD CASUALTY INSURANCE COMPANY

MFDR Tracking Number
M4-19-3816-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
April 16, 2019

Response Submitted By
No response submitted by insurance carrier

REQUESTOR'S POSITION SUMMARY

"Underpaid/Denied Physical Therapy Rate"

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
October 3, 2018 to October 29, 2018	Outpatient Physical Therapy	$182.64	$134.15

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 24, 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:
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - 150 – PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
   - 96 – NON-COVERED CHARGE(S).
   - 797 – SERVICE NOT PAID UNDER MEDICARE OPPS.
   - 886 – THE PROCEDURE WAS INAPPROPRIATELY BILLED. THE PROVIDER HAS PREVIOUSLY BILLED FOR AN INITIAL/EVALUATION VISIT.
   - B16 – PAYMENT ADJUSTED BECAUSE 'NEW PATIENT' QUALIFICATIONS WERE NOT MET

- 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.
- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

1. Did the insurance carrier support its denial of the physical therapy evaluation service?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 886 – THE PROCEDURE WAS INAPPROPRIATELY BILLED. THE PROVIDER HAS PREVIOUSLY BILLED FOR AN INITIAL/EVALUATION VISIT.
   - B16 – PAYMENT ADJUSTED BECAUSE 'NEW PATIENT' QUALIFICATIONS WERE NOT MET

   28 Texas Administrative Code §134.203(b)(1) requires that 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."

   Review of the submitted information finds that the carrier denied evaluation code 97161 inappropriately. Therapy evaluation code 97161 is not comparable to a "new patient" visit code billed by physicians and is not restricted to billing only for patients that have not previously been seen. Therapy code 97161 is for evaluating the current injury or problem and developing a new plan of care for a new course of treatment requested by the referring physician.

   Reevaluation code 97164 is likewise not comparable to an "established patient" visit code billed by physicians. 97164 is used when therapists reevaluate and reassess progress to modify an established plan of care for an ongoing course of treatment. The service in dispute is not a modification of an established care plan.

   The medical record supports that the evaluation was performed to establish a new plan of care for a new course of treatment that had not been ongoing. The submitted documentation supports evaluation code 97161 as billed.

2. This dispute regards outpatient physical 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 of service if Medicare pays it 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.

   Medicare's multiple-procedure payment reduction (MPPR) policy requires the first unit of the therapy code with the highest practice expense be paid in full. Payment is reduced by 50% of the practice expense for each extra unit of therapy (codes with multiple-procedure indicator 5) provided on the same date.

   Reimbursement is calculated as follows:

   - Procedure code 97110 (October 16, October 18, October 22, October 25, and October 29, 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. The PE for this code is not the highest for these dates; payment is reduced by 50% of the practice expense. The PE reduced rate is $38.11 at 3 units is $114.33. The total for 5 visits is $571.65.
   - Procedure code 97112 (October 16, October 18, October 22, October 25, and October 29, 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. This code has the highest PE for these dates. The first unit is paid at $55.79. The total for 5 visits is $278.95.

- Procedure code 97161, October 3, 2018, has a Work RVU of 1.2 multiplied by the Work GPCI of 1 is 1.2. The practice expense RVU of 1.13 multiplied by the PE GPCI of 0.938 is 1.05994. The malpractice RVU of 0.05 multiplied by the malpractice GPCI of 0.796 is 0.0398. The sum is 2.29974 multiplied by the DWC conversion factor of $58.31 for a MAR of $134.10. This code has the highest PE for this date. The payment is $134.10.
- Procedure codes G8978 and G8979 (October 3, 2018) 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 $984.70. The insurance carrier paid $850.55. The amount due is $134.15. 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 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 above, the division finds that additional payment is due. As a result, the amount ordered is $134.15.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, the division finds the requestor is entitled to additional reimbursement. The division hereby ORDERS the respondent to remit to the requestor $134.15, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	July 19, 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.