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 DALLAS

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-19-3817-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 16, 2019

Response Submitted By
The Hartford

REQUESTOR'S POSITION SUMMARY

"Underpaid/Denied Physical Therapy Rate"

RESPONDENT'S POSITION SUMMARY

"These services are processed using Medicare's Physician Fee Schedule rate."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 21, 2018 to November 30, 2018	Outpatient Occupational Therapy	$21.28	$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 insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1115 - WE FIND THE ORIGINAL REVIEW TO BE ACCURATE AND ARE UNABLE TO RECOMMEND ANY ADDITIONAL ALLOWANCE
   - 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.
   - 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.
   - 107 – CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT PREVIOUSLY PAID OR IDENTIFIED ON THIS CLAIM.
   - 246 – THIS NON-PAYABLE CODE IS FOR REQUIRED REPORTING ONLY.

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards outpatient occupational 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:

- Procedure code 97018 (November 21, November 23, , November 28, and November 30, 2018) has a Work RVU of 0.06 multiplied by the Work GPCI of 1.012 is 0.06072. The practice expense RVU of 0.18 multiplied by the PE GPCI of 1.014 is 0.18252. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.768 is 0.00768. The sum is 0.25092 multiplied by the DWC conversion factor of $58.31 for a MAR of $14.63. Payment is reduced by 50% of the practice expense for each extra therapy unit after the first unit of the code with the highest PE billed for each date. The PE for this code is not the highest billed for each date. The PE reduced rate is $9.31, for 4 visits totals $37.24. The carrier paid $37.24. Additional payment is not recommended.

The total allowable reimbursement for the disputed services is $37.24. The insurance carrier paid $37.24. The amount due is $0.00. No additional payment can be 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

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

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	May 10, 2019 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.