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
HARTFORD CASUALTY INSURANCE COMPANY

MFDR Tracking Number
M4-19-4158-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 17, 2019

Response Submitted By
The Hartford

REQUESTOR'S POSITION SUMMARY

"Underpaid/Denied Physical Therapy Rate"

RESPONDENT'S POSITION SUMMARY

"Dates of service in dispute were processed in accordance with Texas Workers' Compensation Guidelines."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 11, 2019 to February 21, 2019	Outpatient Physical Therapy	$26.10	$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. 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:
   - 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.
   - 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.
   - 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. 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.

   Rule §134.403(d)(1) states, "Specific provisions contained in the Texas Labor Code or … (Division) rules … shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program."

   Texas Labor Code §408.021(a) establishes an injured employee's entitlement to medical benefits, stating the employee "is entitled to all health care reasonably required by the nature of the injury as and when needed." The Labor Code's guarantee of medical benefits supersedes any conflicting Medicare payment policy.

   The insurance carrier did not present any information to support that the injured employee or the disputed services were subject to a "benefit maximum." The carrier's denial reason is not supported. These services will therefore be reviewed for reimbursement in accordance with division rules and fee guidelines.

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 97035 (February 11, 2019) has a Work RVU of 0.21 multiplied by the Work GPCI of 1.012 is 0.21252. The practice expense RVU of 0.17 multiplied by the PE GPCI of 1.014 is 0.17238. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.768 is 0.00768. The sum is 0.39258 multiplied by the DWC conversion factor of $59.19 for a MAR of $23.24. The PE for this code is not the highest for this date, payment is reduced by 50% of the practice expense. The PE reduced rate is $18.14.
   - Procedure code 97110 (February 11, 2019) has a Work RVU of 0.45 multiplied by the Work GPCI of 1.012 is 0.4554. The practice expense RVU of 0.4 multiplied by the PE GPCI of 1.014 is 0.4056. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.768 is 0.01536. The sum is 0.87636 multiplied by the DWC conversion factor of $59.19 for a MAR of $51.87. This code has the highest PE for this date. The first unit is paid at $51.87.
   - Procedure code 97110 (February 21, 2019) has a Work RVU of 0.45 multiplied by the Work GPCI of 1.012 is 0.4554. The practice expense RVU of 0.4 multiplied by the PE GPCI of 1.014 is 0.4056. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.768 is 0.01536. The sum is 0.87636 multiplied by the DWC conversion factor of $59.19 for a MAR of $51.87. This code has the highest PE for this date. 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 first unit is paid at $51.87. The PE reduced rate is $39.87. The total for 2 units is $91.74.
   - Procedure code 97140 (February 11 and February 21, 2019) has a Work RVU of 0.43 multiplied by the Work GPCI of 1.012 is 0.43516. The practice expense RVU of 0.35 multiplied by the PE GPCI of 1.014 is 0.3549. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.768 is 0.00768. The sum is 0.79774 multiplied by the DWC conversion factor of $59.19 for a MAR of $47.22. The PE for this code is not the highest for this date, payment is reduced by 50% of the practice expense. The PE reduced rate is $36.71. The total for 2 visits is $73.42.

   The total allowable reimbursement for the disputed services is $235.17. The insurance carrier paid $235.15. Additional payment is not 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 the requestor has not established that additional payment 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	August 9, 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.