TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE FORT WORTH

Respondent Name
HARTFORD ACCIDENT & INDEMNITY COMPANY

MFDR Tracking Number
M4-19-4161-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 17, 2019

Response Submitted By
The Hartford

REQUESTOR'S POSITION SUMMARY

"PLEASE SEE ATTACHED DOCUMENTATION REGARDING MPPR. CARRIER IS TO PAY 80% PAYMENT FOR SERVICES FURNISHED. CARRIER ONLY PAID 66% ON THIS DATE OF SERVICE."

RESPONDENT'S POSITION SUMMARY

"Date of service in dispute was processed in accordance with Texas Workers' Compensation Guidelines, 28 TAC. §134.203."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 25, 2019	Physical Therapy Services	$139.17	$58.35

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 §134.203 sets out the fee guideline for professional medical services.
3. Texas Labor Code §408.021 entitles an injured employee to all required health care as and when needed.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 163 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE UNIT VALUE AND/OR MULTIPLE PROCEDURE RULES
   - 119 – BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
   - 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.
   - 1115 - WE FIND THE ORIGINAL REVIEW TO BE ACCURATE AND ARE UNABLE TO RECOMMEND ANY ADDITIONAL ALLOWANCE

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 payment for 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 applicable to Medicare beneficiaries.

   Injured employees' entitlement to medical benefits is set out in Texas Labor Code §408.021(a), which provides that an employee "is entitled 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. This dispute regards medical services with reimbursement subject to the *Medical Fee Guideline for Professional Services*, 28 Texas Administrative Code §134.203, requiring the maximum allowable reimbursement (MAR) be determined by 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.

   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, February 25, 2019, 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 $59.19 for a MAR of $51.05. The PE for this code is not the highest; payment is reduced by 50% of the practice expense. The PE reduced rate is $39.38 at 4 units is $157.52.
   - Procedure code 97112, February 25, 2019, has a Work RVU of 0.5 multiplied by the Work GPCI of 1.007 is 0.5035. The practice expense RVU of 0.47 multiplied by the PE GPCI of 0.986 is 0.46342. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.747 is 0.01494. The sum is 0.98186 multiplied by the DWC conversion factor of $59.19 for a MAR of $58.12. This code has the highest PE. For each extra therapy unit after the first, payment is reduced by 50% of the practice expense. The first unit is paid at $58.12. The PE reduced rate is $44.40. The total for 2 units is $102.52.
   - Procedure code 97140, February 25, 2019, 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 $59.19 for a MAR of $46.50. The PE for this code is not the highest; payment is reduced by 50% of the practice expense. The PE reduced rate is $36.29 at 2 units is $72.58.

   The total allowable reimbursement for the disputed services is $332.62. The insurance carrier paid $274.27. The amount due is $58.35. 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 $58.35.

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 $58.35, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	June 14, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). 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 field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute 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.