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
UT HEALTH EAST TEXAS REHABILITATION HOSPITAL

Respondent Name
ACCIDENT FUND GENERAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-4445-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
June 10, 2019

Response Submitted By
No response received

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
March 4, 2019 to March 28, 2019	Outpatient Physical Therapy	$212.15	$212.15

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. Insurance Code Chapter 1305 sets out requirements for certified workers' compensation health care networks.
5. The division provided a copy of the Medical Fee Dispute Resolution request to the insurance carrier's Austin representative, receipt acknowledged June 18, 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.
6. 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.
   - 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
   - 877 – REIMBURSEMENT IS BASED ON THE CONTRACTED AMOUNT.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

Issues

1. Did the insurance carrier respond to the medical fee dispute?
2. Are the services subject to a contract between the parties to this dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The Austin carrier representative for Accident Fund General Insurance Company is Stone Loughlin Swanson, LLP, who acknowledged receipt of a copy of the MFDR request on June 18, 2019. Pursuant to Rule §133.307(d)(1), if the division does not receive a response within 14 calendar days of dispute notification, the division may base its decision on the available information. To date, no response has been received. Consequently, this decision is based on the information available at the time of review.
2. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - 877 – REIMBURSEMENT IS BASED ON THE CONTRACTED AMOUNT.

   Based on information maintained by the division, the insurance carrier has not previously reported to the division that the injured employee is enrolled in or that the employee's claim is subject to a certified workers' compensation health care network (HCN) established in accordance with Insurance Code Chapter 1305.

   The respondent did not present any documentation to support the claim is subject to a certified workers' compensation HCN, nor did the respondent provide any evidence of a contract between the insurance carrier and the provider or between the provider and a workers' compensation HCN to which the carrier had access.

   No evidence was found to support a contracted amount or negotiated agreement applicable to the disputed services. The division thus concludes the insurance carrier's payment reduction reasons are not supported. Reimbursement for the services will therefore be considered in accordance with division rules and fee guidelines.
3. 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 97032 (March 4, March 7, March 20, March 22, March 25, and March 28, 2019) has a Work RVU of 0.25 multiplied by the Work GPCI of 1 is 0.25. The practice expense RVU of 0.16 multiplied by the PE GPCI of 0.938 is 0.15008. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.796 is 0.00796. The sum is 0.40804 multiplied by the DWC conversion factor of $59.19 for a MAR of $24.15. 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 $19.71. The total for 6 visits is $118.26.
   - Procedure code 97110, March 20, 2019, 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 $59.19 for a MAR of $49.79. This code has the highest PE for this date. For each extra therapy unit after the first, payment is reduced by 50% of the practice expense. The first unit is paid at $49.79. The PE reduced rate is $38.68. The total for 2 units is $88.47.

- Procedure code 97110 (March 4, March 7, March 22, March 25, and March 28, 2019) 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 $59.19 for a MAR of $49.79. This code has the highest PE for these dates. 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 $49.79. The PE reduced rate is $38.68 at 2 units is $77.36. The total for 3 units is $127.15. Multiplied by 5 visits is $635.75.

The total allowable reimbursement for the disputed services is $842.48. The insurance carrier paid $570.00. The requestor is seeking additional reimbursement of $212.15. 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 $212.15.

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 $212.15, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	August 16, 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.