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
ELITE HEALTHCARE FORT WORTH

Respondent Name
ZURICH AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-19-4726-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 1, 2019

Response Submitted By
No response received

REQUESTOR'S POSITION SUMMARY

"CARRIER IS NOT PAYING ACCORDING TO AUTHORIZATION OUR FACILITY RECEIVED REGARDING THIS PATIENT."

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
February 12, 2019	Outpatient Physical Therapy: CPT 97110	$125.44	$78.76

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 (DWC).

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:
   - W3 – Additional payment made on appeal/reconsideration.
   - 1014 - The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - 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
   - 163 – The charge for this procedure exceeds the unit value and/or multiple procedure rules

Issues

1. Did the insurance carrier respond to the request for medical fee dispute resolution (MFDR)?
2. Is the injured employee subject to a benefit maximum?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The Austin carrier representative for Zurich American Insurance Company is Flahive, Odgen & Latson, Attorneys at Law, PC, who acknowledged receipt of a copy of the MFDR request on July 9, 2019.

   28 Texas Administrative Code §133.307(d)(1) provides if the division does not receive a response within 14 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 code:
   - 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

   28 Texas Administrative Code §134.203(a)(7) states, "Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program."

   While DWC has adopted Medicare *payment* policies in administering the workers' compensation medical fee guidelines, it has not adopted Medicare's *benefit* limitations. Texas Labor Code §408.021(a) entitles injured employees "to all health care reasonably required by the nature of the injury as and when needed." The Labor Code's guarantee of medical benefits thus supersedes any conflicting Medicare benefit policy.

   The respondent did not present information to support that the injured employee or the disputed services were subject to a "benefit maximum," or that the charge "exceeds the unit value." These denial reasons are not supported. The services will therefore be reviewed for reimbursement in accordance with DWC fee guidelines.

3. This dispute regards outpatient physical therapy services with reimbursement subject to 28 TAC §134.203(c), which 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 payment in full for the first unit of therapy with the highest practice expense. Payment is reduced by 50% of the practice expense for each extra therapy unit (codes with multiple-procedure indicator 5) provided on the same day.

   Reimbursement is calculated as follows:

   - Procedure code 97110, February 12, 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 billed for this date; payment is thus reduced by 50% of the practice expense. The PE reduced rate is $39.38 at 4 units is $157.52.

   The total allowable reimbursement for CPT 97110 is $157.52. The insurance carrier paid $78.76.
   The amount remaining due is $78.76. 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.

The requestor has established that additional payment is due. As a result, the amount ordered is $78.76.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $78.76, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	September 13, 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 28 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.