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 ARLINGTON MEMORIAL HOSPITAL

Respondent Name
ZURICH AMERICAN INSURANCE CO.

MFDR Tracking Number
M4-19-4728-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 1, 2019

Response Submitted By
Flahive, Odgen & Latson, Attorneys at Law, PC

REQUESTOR'S POSITION SUMMARY

"Underpaid/Denied Physical Therapy Rate: Phys Conversion Factor applied to Hospital Service."

RESPONDENT'S POSITION SUMMARY

"The provider is not entitled to additional reimbursement nor is the provider entitle to Medical Fee Dispute Resolution through the Medical Review Division."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 2, 2019 to January 28, 2019	Outpatient Occupational Therapy	$81.68	$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. 28 Texas Administrative Code §133.240 sets out requirements regarding medical bill payments and denials.
5. Texas Labor Code §413.031 entitles a provider to a review of services if payment is reduced or denied.
6. Texas Insurance Code Chapter 1305 sets out requirements for workers' compensation health care networks.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 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.
   - 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.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

1. Is the injured employee's claim subject to a certified workers' compensation health care network?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent asserts the health care provider is not entitled to Medical Fee Dispute Resolution "because the claimant is in the Coventry Health Care Network. Review of records maintained by the division finds no previous notification to the division that the injured employee is enrolled in a certified workers' compensation health care network (HCN) established in accordance with Insurance Code Chapter 1305. Nor did the respondent present any documentation to support payment is subject to the provisions of a certified workers' compensation HCN.

   Rule §133.240(f)(15) further requires any explanations of benefits (EOB) to include the "workers' compensation health care network name (if applicable)" when the carrier pays or denies a bill. Review of the submitted EOBs finds no reference to the name of any certified workers' compensation HCN. The insurance carrier failed to meet the requirements of Rule §133.240(f)(15) and thus failed to give proper notice to the provider.

   28 Texas Administrative Code §133.307(d)(2)(F) requires, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   The insurance carrier's failure to give notice to the health care provider of the name of any applicable certified workers' compensation HCN on the explanations of benefits — or at any time before the filing of the medical fee dispute request — constitutes grounds for the division to find a waiver of such defenses during dispute resolution. The division finds that the insurance carrier has waived the right to raise such a defense in this dispute.

   Based on the available information, the division concludes the respondent failed to support the claim is subject to a certified HCN. Moreover, the respondent has waived the right to raise such a defense at MFDR. Consequently, this dispute is eligible for dispute resolution. The services will thus be reviewed in accordance with division rules.

2. 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 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 97140 (January 2, January 3, January 7, January 14, January 21, January 24, 2019, and January 28, 2019) has a Work RVU of 0.43 multiplied by the Work GPCI of 1.007 is 0.433. 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 for these dates; payment is reduced by 50% of the practice expense. The PE reduced rate is $36.29. The total for 7 visits is $254.03.
   - Procedure code 97140, January 10, 2019, has a Work RVU of 0.43 multiplied by the Work GPCI of 1.007 is 0.433. 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 for this date; payment is thus 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 $326.61. The insurance carrier paid $326.52. 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	July 26, 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.