



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

STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number

M4-19-5025-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

July 29, 2019

Response Submitted By

State Office of Risk Management

REQUESTOR'S POSITION SUMMARY

"THIS IS AN INCORRECT DENIAL FROM THE CARRIER. CARRIER IS NOT PAYING ACCORDING TO AUTHORIZATION OUR FACILITY RECEIVED REGARDING THIS PATIENT."

RESPONDENT'S POSITION SUMMARY

"Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c)."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 11, 2019	Professional Medical Services	\$218.44	\$151.34

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
- Texas Labor Code §408.021 entitles an injured employee to all required health care as and when needed.
- 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
 - 168 – BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES
 - 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.
 - 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.

Issues

- Are the disputed services subject to a benefit maximum, maximum unit value, or daily maximum allowance?
- 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
- 168 – BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES

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 §134.203(a)(7) states, "Specific provisions contained in the Texas Labor Code or ... (Division) rules ... shall take precedence over any conflicting provision adopted or utilized by 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 thus supersedes any conflicting Medicare payment policy.

The respondent did not present information to support the injured employee or disputed services were subject to a "benefit maximum," "maximum unit value," or "maximum daily allowance." The carrier's denial reasons are not supported. These services will thus be reviewed for payment following 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 therapy with the highest practice expense be paid in full. 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 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. The carrier paid \$78.76. The amount due is \$78.76.
- Procedure code 97140 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 carrier paid \$0.00. The amount due is \$72.58.

The total allowable reimbursement for the disputed services is \$230.10. The insurance carrier paid \$78.76.

The amount remaining due is \$151.34. 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 additional payment is due. As a result, the amount ordered is \$151.34.

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 \$151.34, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

August 23, 2019
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.