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 REHAB

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-19-5041-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
July 30, 2019

Response Submitted By
State Office of Risk Management

REQUESTOR'S POSITION SUMMARY

"Per our Texas Fee Schedule Calculations, this bill has been underpaid."

RESPONDENT'S POSITION SUMMARY

"reimbursement was made for CPT 97110 X 1 unit as preauthorized pursuant to the Division's rules and payment policies."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 11, 2018 to September 27, 2018	Outpatient Physical Therapy	$176.60	$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 §134.600 sets out guidelines for preauthorization of health care.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.
   - 6553 - CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
   - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
   - 6545 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 5080 – BASED ON THE RECEIPT OF ADDITIONAL INFORMATION AND/OR CLARIFICATION, WE ARE RECOMMENDING FURTHER PAYMENT BE MADE FOR THE ABOVE NOTED PROCEDURE CODE(S).

Issues

1. Were the disputed services preauthorized?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 6553 - CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
   - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.

   28 Texas Administrative Code §134.600(p)(5)(C) states that non-emergency health care requiring preauthorization includes physical and occupational therapy services…

   The requestor did not provide any information to support that the disputed services were preauthorized.

   The respondent provided documentation to support that only CPT code 97110 was preauthorized.

   Based on the information presented for review, the above denial reasons are supported. Accordingly, additional payment cannot be recommended for therapy services billed under CPT code 97140.

2. 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.

   Reimbursement is calculated as follows:

   - CPT code 97110 (September 11, September 21, September 26, and September 27, 2018) 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 $58.31 for a MAR of $49.05. The total for 4 visits is $196.20.

   The total allowable reimbursement for the disputed services is $196.20. The insurance carrier paid $196.20. The amount remaining due is $0.00. No additional payment is recommended.

Conclusion

The division finds the requestor has not established that additional payment is due. 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

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.

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.