TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Capitol Home Health Inc

Respondent Name
Hartford Casualty Insurance Co

MFDR Tracking Number
M4-19-5043-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 30, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I've corrected G0151 to 97110 since this particular code does have an allowance in the TX Medicaid fee schudule."

Amount in Dispute: $1,140.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "HCPC G0151 US GP & CPT 97110 US GP does not have an allowance in the Texas Medicaid Home Health Agency Fee Schedule for the date of service in dispute."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 11, 2019	Physical therapy services	$1,140.00	$126.57

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §134.215 sets out the fee guidelines for home health services
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 181 – Payment adjusted because this procedure code was invalid on the date of service
   - 4142 – The billed service has not allowance in Texas Medicaid Home Health Agency Fee Schedule

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking $1,140.00 for physical therapy service rendered on January 11, 2019. The insurance carrier denied disputed services with based on the submitted HCPCS Code of G0151. The requestor submitted a corrected claim on February 22, 2019 indicating a HCPCS Code of 97110 which is a valid code in the Texas Medicaid system.

   The insurance carrier did not process this corrected claim. The service in dispute will be reviewed based on applicable fee guideline.

2. 28 TAC §134.215 sets out the reimbursement guideline of "The maximum allowable reimbursement (MAR) amount for home health services provided through a licensed home health agency shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies." Review of the Texas Medicaid Fee Guideline found an allowable of $33.75 per unit. The calculation of the allowable is $33.75 x 125% x 3 = $126.57. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $126.57.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $126.57, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

Signature	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, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

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 instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 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.