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 FORT WORTH

Respondent Name
TRAVELERS INDEMNITY COMPANY

MFDR Tracking Number
M4-18-3815-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
June 5, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Physical therapy services have not been reimbursed per state fee schedule rules."

Amount in Dispute: $73.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the calculations and determined the Provider was properly reimbursed."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 28, 2017	Outpatient Facility Services – Physical Therapy	$73.31	$42.73

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 §134.403 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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - 96 – NON-COVERED CHARGE(S).
   - 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.
   - 246 – THIS NON-PAYABLE CODE IS FOR REQUIRED REPORTING ONLY.
   - 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.
   - 4278 - THIS NON-PAYABLE G CODE BILLED WITH OR WITHOUT AN APPROPRIATE MODIFIER IS FOR REPORTING PURPOSES ONLY.

Issues

1. What is the recommended payment for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards physical therapy services performed in an outpatient hospital facility setting. Such services are not paid under Medicare's Outpatient Prospective Payment System but rather under Medicare's Physician Fee Schedule for professional services.

   Rule §134.403(h) requires that if Medicare pays using other Medicare fee schedules, reimbursement shall be made using the DWC fee guideline applicable to the code on the date the service was provided. Accordingly, payment for these services is calculated under the DWC Medical Fee Guideline for Professional Services, Rule §134.203(c).

   Medicare assigns each service a relative value unit (RVU) for work, practice expense and malpractice. The RVUs are adjusted by provider geographic practice cost indexes (GPCI). The Medicare fee is the sum of the RVUs multiplied by a conversion factor. The maximum allowable reimbursement (MAR) is calculated by substituting the Texas DWC conversion factor. The applicable division conversion factor for calendar year 2017 is $57.50.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 97162 has a Work relative value unit (RVU) of 1.2 multiplied by the Work geographic practice cost index (GPCI) of 1.006 is 1.2072. The practice expense RVU of 1 multiplied by the PE GPCI of 0.991 is 0.991. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.76 is 0.076. The sum is 2.2742 multiplied by the DWC conversion factor of $57.50 for a MAR of $130.77.
   - Procedure codes G8978 and G8979 have status indicator Q, denoting functional information codes used for reporting purposes only. No separate payment is made.

2. The total allowable reimbursement for the disputed services is $130.77. The insurance carrier paid $88.04. The amount due is $42.73. 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 $42.73.

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 $42.73, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	July 3, 2018
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 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.