



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

DETAR HEALTHCARE SYSTEM

Respondent Name

VICTORIA INDEPENDENT SCHOOL DISTRICT

MFDR Tracking Number

M4-18-4592-01

Carrier's Austin Representative

Box Number 21

MFDR Date Received

July 31, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim has been previously denied by the payer. . . . It was worked by a Senior Revenue Specialist from 10/21/17 until 7/24/18. And it has not been paid correctly"

Amount in Dispute: \$121.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "payment issued on 3/14/18 was correct and no further reimbursement is due."

Response Submitted by: CAS, Claims Administrative Services, Inc.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Dispute Amount, Amount Due. Row 1: October 4, 2017 to October 13, 2017, Outpatient Facility Services – Physical Therapy, \$121.60, \$0.00

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:
- 197 – PRECERTIFICATION/AUTHORIZATION ABSENT
- 721 – PER RULE 134.600 OF THE TEXAS ADMINISTRATIVE CODE, THIS PROCEDURE REQUIRES PREAUTHORIZATION, PREAUTHORIZATION NOT OBTAINED.
- 356 – THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS THE TEXAS MARKUP.
- 617 – THIS ITEM OR SERVICE IS NOT COVERED OR PAYABLE UNDER THE MEDICARE OUTPATIENT FEE SCHEDULE.
- 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 650 – ALLOWANCE IS REDUCED PER THE MULTIPLE PROCEDURE PAYMENT REDUCTION FOR SELECTED THERAPY SERVICES.

- 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services, in part, with claim adjustment reason codes:
 - 197 – PRECERTIFICATION/AUTHORIZATION ABSENT
 - 721 – PER RULE 134.600 OF THE TEXAS ADMINISTRATIVE CODE, THIS PROCEDURE REQUIRES PREAUTHORIZATION, PREAUTHORIZATION NOT OBTAINED.

Review of the submitted information finds that upon reconsideration of the bill, the insurance carrier did not maintain these reasons. These denial reasons are therefore no longer in dispute and not supported. As a result, the disputed services will be reviewed for payment in accordance with applicable division rules and fee guidelines.

2. 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 these values multiplied by a conversion factor. The maximum allowable reimbursement (MAR) is calculated by substituting the DWC conversion factor. The applicable division conversion factor for calendar year 2017 is \$57.50.

Per Medicare payment policy, when more than one unit is billed of therapy services with multiple procedure payment indicator '5', the first unit of the therapy with the highest practice expense for that day is paid in full. Payment is reduced by 50% of the practice expense (PE) for each extra therapy unit performed on that date.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 97110, October 4, 2017, 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. Payment is reduced by 50% of the practice expense for each extra therapy unit after the first unit of the code with the highest practice expense for that date. This code has the highest PE for this date. The first unit is paid at \$49.05. The PE reduced rate is \$38.11. The total for 2 units is \$87.16.
- Procedure code 97140, October 4, 2017, has a Work RVU of 0.43 multiplied by the Work GPCI of 1 is 0.43. The practice expense RVU of 0.35 multiplied by the PE GPCI of 0.938 is 0.3283. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.796 is 0.00796. The sum is 0.76626 multiplied by the DWC conversion factor of \$58.31 for a MAR of \$44.68. Payment is reduced by 50% of the practice expense for each extra therapy unit after the first unit of the code with the highest practice expense for that date. The PE for this code is not the highest. The PE reduced rate is \$35.11.
- Procedure code 97014, October 4, 2017, has status indicator I — code not valid for Medicare purposes. Medicare uses another code for reporting this service. Reimbursement cannot be recommended.

- Procedure code 97110, October 6, 2017, 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. For each extra therapy unit, payment is reduced by 50% of the practice expense. This code has the highest PE. The first unit is paid at \$49.05. The PE reduced rate is \$38.11. The total for 2 units is \$87.16.
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 - Procedure code 97014, October 13, 2017, has status indicator I — code not valid for Medicare purposes. Medicare uses another code for reporting this service. Reimbursement cannot be recommended.
3. The total allowable reimbursement for the disputed services is \$489.08. The insurance carrier paid \$524.20. No additional payment 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 division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, 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 17, 2018
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 DWCO45M) 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.