



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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Bodies in Balance

Respondent Name

Insurance Co of the State of Pennsylvania

MFDR Tracking Number

M4-14-1056-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

December 9, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...we spoke with Miss Maria Beavan with UR dept She faxed the authorization letter to my attention, request made for (claimant) to attend our facility due to language barriers and transportation issues at Concentra clinic, attached letter, Miss Beavan stated no need to switch facilities, patient may use any facility of his choice..."

Amount in Dispute: \$1,525.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...Preauthorization for six sessions of physical therapy for the right shoulder was requested an approved by another facility... The carrier denied the \$1,525.00 charge and requested additional information from Bodies in Balance... I do not find the requested information needed to process the bill..."

Response Submitted by: AIG, 4100 Alpha Rd. Ste 700, Dallas, TX 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 14 – 23, 2013	Physical Therapy	\$1,525.00	\$1,485.70

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 4 – The procedure code is inconsistent with the modifier used or a required modifier.

Issues

1. Were the services in dispute prior authorized?
2. Was the medical bill submitted with correct procedure code/modifier?
3. What is the applicable rule for calculating Maximum Allowable Reimbursement?
4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600 (p) states, "(p) Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services," Review of the submitted documentation finds the health care was prior authorized.
2. The carrier denied the disputed services as, "4 – "The procedure code is inconsistent with the modifier used or a required modifier." Texas Administrative Code §134.203 states in pertinent parts, (b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. Review of the Centers for Medicare and Medicaid Services, Claims Processing Manual, Chapter 5, Section 20.1 states in relevant portion, "The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered: GP Services delivered under an outpatient physical therapy plan of care." Review of the submitted documentation finds the requestor met the applicable Medicare payment policy in effect on the date of service. The carrier's denial is not supported. Therefore, the claims in dispute will be reviewed per applicable fee guidelines and rules.

3. 28 Texas Administrative Code 134.203(c) states, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (current year conversion factor). Reimbursement for the dispute services is calculated as follows:

Procedure code 97001, service date August 14, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.2 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 1.2108. The practice expense (PE) RVU of 0.95 multiplied by the PE GPCI of 1.002 is 0.9519. The malpractice RVU of 0.05 multiplied by the malpractice GPCI of 0.923 is 0.04615. The sum of 2.20885 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$122.15. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at \$122.15. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is \$85.00.

Procedure code 97140, service date August 14, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.43387. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.002 is 0.44088. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.923 is 0.00923. The sum of 0.88398 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$48.88. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$36.69.

Procedure code 97112, service date August 14, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.45405. The practice expense (PE) RVU of 0.52 multiplied by the PE GPCI of 1.002 is 0.52104. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.923 is 0.00923. The sum of 0.98432 is multiplied by the Division conversion factor of \$55.30 for a

MAR of \$54.43. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$40.03 at 2 units is \$80.06. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is \$80.00.

Procedure code 97110, service date August 14, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.45405. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 1.002 is 0.48096. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.923 is 0.00923. The sum of 0.94424 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$52.22. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$38.92 at 3 units is \$116.76.

Procedure code 97140, service date August 15, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.43387. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.002 is 0.44088. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.923 is 0.00923. The sum of 0.88398 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$48.88. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$36.69.

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Procedure code 97110, service date August 15, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.45405. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 1.002 is 0.48096. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.923 is 0.00923. The sum of 0.94424 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$52.22. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$38.92 at 3 units is \$116.76.

Procedure code 97140, service date August 16, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.43387. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.002 is 0.44088. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.923 is 0.00923. The sum of 0.88398 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$48.88. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense.

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Procedure code 97140, service date August 19, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.43387. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.002 is 0.44088. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.923 is 0.00923. The sum of 0.88398 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$48.88. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$36.69.

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4. The total allowable reimbursement for the services in dispute is \$1,485.70. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$1,485.70. 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 \$1,485.70.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,485.70 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

July , 2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §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 MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **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.