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
ELITE HEALTHCARE GARLAND

Respondent Name
ACCIDENT FUND GENERAL INSURANCE

MFDR Tracking Number
M4-14-1126-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
DECEMBER 17, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Physical Therapy for the attached date of service, 09/05/2013, has been denied due to BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED. However, the original claim was submitted on 09/20/2013 and received by Accident Fund and processed on 10/21/2013 and returned partially paid. I resubmitted the request to the carrier with the preauthorization letter attached that no units or codes were specified. I then received a second denial stating 'THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST FO [sic] THE PROVIDER AND ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION' however the request was a reconsideration for the partial amount that was not received. However per Rule 134.600 once a preauth is issued the carrier shall not withdraw a preauthorization or concurrent review approval once issued the carrier shall not withdraw a preauthorization or concurrent review approval one a preauth is issued. This date should have been paid in full. I have attached all necessary documentation."

Amount in Dispute: $203.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor seeks additional reimbursement of $203.52 for physical therapy services provided to the claimant on 09/05/13. The bill was processed correctly under the Medical Fee Guidelines. Four units were recommended for procedure codes 97112 and 97110, as these codes have a higher value than code 97140."

Response Submitted by: STONE LOUGHLIN & SWANSON, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 5, 2013	CPT Codes: 97110 and 97140	$203.52	$124.82

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 §134.203 sets out the fee guidelines for professional services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 119 – Benefit maximum for this time period or occurrence has been reached.
   - 168 – Billed charge is greater than maximum value or daily maximum allowance.
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review be correct. Therefore, no additional allowance appears to be warranted.
   - W3 – Additional payment made on appeal/reconsideration.

Issues

1. Did the request or exceed the daily maximum allowance for physical therapy/physical medicine services?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied the services in dispute using denial codes 119 – "Benefit maximum for this time period or occurrence has been reached" and 168 – "Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services." Review of the preauthorization approval finds CPT Codes 97110, 97112 and 97140 were approved for the left ankle, 3xWkx2Wk equaling 6 sessions starting October 18, 2013 and ending November 15, 2013. The Division finds that the respondent did not limit the number of units of 97110 and 97140 on the preauthorization report; therefore, the respondent's denial based upon reason codes "168 and 119" is not supported.
2. In accordance with 28 Texas Administrative Code §134.203(c) reimbursement is as follows:
   - Procedure code 97140, service date September 5, 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 1.017 is 0.44748. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 0.88969 is multiplied by the Division conversion factor of $55.30 for a MAR of $49.20. 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 $36.83 at 2 units is $73.66. The insurance carrier did not reimburse this code; therefore, reimbursement in the amount of $73.66 is recommended.
   - Procedure code 97110, service date September 5, 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 1.017 is 0.48816. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.834 is 0.00834. The sum of 0.95055 is multiplied by the Division conversion factor of $55.30 for a MAR of $52.57. 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 $39.07 at 4 units is $156.28. The insurance carrier paid $105.12; therefore, reimbursement of $51.16 ($156.28 - $105.12) 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 $124.82 ($73.66 + $51.16).

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 $124.82 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		June 27, 2014
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 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.