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 and Address
ERIC A VANDERWERFF DC
615 N OCONNOR ROAD 12
IRVING TX 75061

Respondent Name
EAST TX EDUCATIONAL INS ASSN

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-14-1328-01

MFDR Date Received
JANUARY 13, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "**THESE ARE PRE-AUTHORIZED SERVICES AND SHOULD BE PAID IN FULL**."

Amount in Dispute: $2,142.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This letter is in response to the Medical Dispute Resolution…On 2/18/13, Pre-authorization # [redacted] allowed for physical therapy to include 6 sessions, any combination of CPT 97140, 97110, 97112, G0283, 97116 and 98943, for a maximum of 4 units per session, for service dates 2/18/13-3/22/13. We paid 6 sessions (4 units per session) for dates of service 2/18, 2/21, 2/25, 3/7, 3/11 and 3/14/13. On 3/14/14, Pre-authorization #42538 allowed for physical therapy to include 6 sessions, any combination of CPT 97140, 97110, 97112, G0283, 98943 for a maximum of 4 units per session, for service dates 3/14-4/14/13. We paid 6 sessions (4 units per session) for dates of service, 3/18, 3/21, 3/25, 3/28, 4/1 and 4/4/13. Each pre-authorization allowed a maximum of 4 units per session, however, Millennium Chiropractic billed each session with 7 or more units. Units in excess of 4 per session were denied as over pre-authorization allowance. With this being said, CPT 98943, Chiropractic Manipulation, was included on each preauthorization. This service does not require preauthorization and payment was issued in addition to the 4 units per session allowed. It is our position that based on the pre-authorizations obtained, the payments issued were correct and no further reimbursement is due."

Response Submitted by: Claims Administrative Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 18, 2013 February 21, 2013 February 25, 2013 March 7, 2013 March 11, 2013 March 21, 2013 March 25, 2013 March 28, 2013 April 1, 2013 April 4, 2013	CPT Code G0283-GP Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care	$24.00/day	$0.00

February 18, 2013 February 21, 2013 February 25, 2013 March 7, 2013 March 11, 2013 March 14, 2013 March 25, 2013	CPT Code 97112-59-GP Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	$47.56/day	$0.00
February 18, 2013 February 21, 2013 February 25, 2013 March 7, 2013 March 11, 2013 March 14, 2013 March 18, 2013 March 21, 2013 March 25, 2013 March 28, 2013 April 1, 2013 April 4, 2013	CPT Code 97116-59-GP Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	$40.48/day	$0.00
February 21, 2013 February 25, 2013 March 7, 2013 March 11, 2013 March 14, 2013 March 18, 2013 March 21, 2013 March 25, 2013 March 28, 2013 April 1, 2013 April 4, 2013	CPT Code 97140-59-GP Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	$85.00/day	$0.00
March 18, 2013 March 21, 2013 March 28, 2013 April 1, 2013 April 4, 2013	CPT Code 97110-GP Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	$46.76/day	$0.00
TOTAL		$2,142.48	$0.00

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, effective July 1, 2012, requires preauthorization for physical therapy services.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 0790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - 0238-Services exceed authorized approval by the managed care service.
   - W1-workers' compensation jurisdictional fee schedule adjustment.
   - 197-percertification/authorization/notification absent.
   - 198-Payment denied/reduced for exceeded precertification/authorization.
   - 720-Preauthorization was approved for a maximum of 4 units per session. Units billed exceed preauthorization amount for date of service.
   - Preauthorization number 41753A and 42538, allowed up to 4 units per session. Our records indicate 4 units were paid for each session. No further reimbursement is due.

Issues

1. Did the requestor exceed the number of units preauthorized for each disputed date of service?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent reduced payment for the disputed services based upon reason codes "0238-Services exceed authorized approval by the managed care service ," "197-percertification/authorization/notification absent ," "198-Payment denied/reduced for exceeded precertification/authorization ," and "720-Preauthorization was approved for a maximum of 4 units per session. Units billed exceed preauthorization amount for date of service."

   28 Texas Administrative Code §134.600 (p)(5) requires preauthorization for physical therapy services.

   The requestor states that "**THESE ARE PRE-AUTHORIZED SERVICES AND SHOULD BE PAID IN FULL**." In support of their position, the requestor submitted copies of preauthorization reports that indicate the following:

   - On February 18, 2013, preauthorization was obtained for 6 session of PT to right ankle, maximum 4 units per session in any combination of 87140, 97110, 97112, G0283, 97116, 98943. No previous PT has been completed.
   - On March 14, 2013, preauthorization was obtained for 6 sessions of continued PT/chiropractic manipulation to right ankle, maximum 4 units per session in any combination of 97140, 97110, 97112, G0283, 98943. 6 previous PT has been completed for a total of 12 sessions.

   The respondent states that "Each pre-authorization allowed a maximum of 4 units per session, however, Millennium Chiropractic billed each session with 7 or more units. Units in excess of 4 per session were denied as over pre-authorization allowance."

   The Division finds that the submitted documentation supports that the requestor obtained preauthorization for four (4) units per session.

   28 Texas Administrative Code §134.203(a)(5), states "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 Texas Administrative Code §134.203 (b)(1) states " 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

   To clarify what a "unit" means, the Division referred to the following references published by the Centers for Medicare & Medicaid Services(CMS) :

   - Medicare Claims Processing Manual, Chapter 5, Part B Outpatient Rehabilitation, publication 100-04, states "When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe ("untimed" HCPCS), the provider enters "1" in the field labeled units. For untimed codes, units are reported based on the number of times the procedure is performed, as described in the HCPCS code definition (often once per day)… Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any single calendar day** using CPT codes and the appropriate number of 15 minute units of service."

   - FACT SHEET, September 2011: Billing Procedure/Modality Units: Many Healthcare Common Procedure Coding System (HCPCS) codes where the procedure is not defined by a specific time frame (untimed), are reported using "1" in the unit field (e.g., HCPCS codes for therapy evaluations, group therapy, and supervised modalities). However, a few untimed codes, "add-on" codes for example, are reported based on the number of times the procedure is performed (e.g., an add-on HCPCS debridement code is billed, in addition to its "base" code, for each additional 20 square centimeters of tissue removed).

     Some HCPCS codes specify that direct (one-on-one) time spent in patient contact is 15 minutes. In those cases, the units are the appropriate number of 15-minute units of services. When only one

service is provided in a day, a service performed for less than eight minutes should not be billed. When more than one unit of service is provided, the initial and subsequent services must total at least 15 minutes, and the last unit may be counted as a full unit of service if at least eight minutes of additional service has been furnished.

Total treatment minutes of the patient, including those minutes of active treatment reported under the timed codes and those minutes represented by the untimed codes, must be documented.

Based upon CMS's definition of units, CPT code G0283 equals one unit based on the number of times the procedure is performed; and codes 97110, 97112, 97116 and 97140 equal one unit for each 15-minute of treatment.

In order to determine if the requestor exceeded the number of physical therapy services preauthorized, the Division reviewed the billing and EOBs and finds the following:

DATE	SERVICES BILLED	TOTAL NUMBER OF UNITS BILLED	TOTAL NUMBER OF UNITS PAID
2/18/2013	G0283-GP 97110-GP (X4) 97112-59-GP 97116-59-GP	7	4
2/21/2013	G0283-GP 97140-59-GP (2) 97110-GP (X4) 97112-59-GP 97116-59-GP	9	4
2/25/13	G0283-GP 97140 -59-GP 97110-GP (X4) 97112-59-GP 97116-59-GP	8	4
3/7/13	G0283-GP 97140-59-GP (2) 97110-GP (X4) 97112-59-GP 97116-59-GP	9	4
3/11/13	G0283-GP 97140-59-GP (2) 97110-GP (X4) 97112-59-GP 97116-59-GP	9	4
3/14/13	G0283-GP 97140-59-GP (2) 97110-GP (X4) 97112-59-GP 97116-59-GP	9	5
3/18/13	G0283-GP	9	5

	97140-59-GP (2) 97110-GP (X4) 97112-59-GP 97116-59-GP		
3/21/13	G0283-GP 97140 -59-GP 97110-GP (X4) 97112-59-GP 97116-59-GP	8	4
3/25/13	G0283-GP 97140-59-GP (2) 97110-GP (X4) 97112-59-GP 97116-59-GP	9	4
3/28/13	G0283-GP 97140-59-GP (2) 97110-GP (X4) 97112-59-GP 97116-59-GP	9	4
4/1/13	G0283-GP 97140-59-GP (2) 97110-GP (X4) 97112-59-GP 97116-59-GP	9	4
4/4/13	G0283-GP 97140-59-GP (2) 97110-GP (X4) 97112-59-GP 97116-59-GP	9	4

The Division concludes that the requestor exceeded the number of units preauthorized per session; therefore, the respondent's denial of reimbursement based upon reason codes 0238, 197, 198 and 720 is supported.

Furthermore, the Division reviewed the respondent's payment for the four preauthorized physical therapy units, and finds that payment was in accordance with the Division's guidelines. As a result, reimbursement cannot be 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 $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		02/25/14
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.

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