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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE FORT WORTH

Respondent Name
HARTFORD CASUALTY INSURANCE COMPANY

MFDR Tracking Number
M4-14-1741-02

Carrier's Austin Representative
Box Number 47

MFDR Date Received
February 14, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient has authorization for physical therapy. . . . These are not duplicates."

Amount in Dispute: $397.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation has found that reimbursement was reduced or denied as per Medicare Guidelines there is a 60 minute maximum allowed for constant attendance modalities and therapeutic codes."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 21, 2013 to November 25, 2013	Physical Therapy	$397.56	$202.86

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 §19.2009 sets out notice requirements for utilization review determinations.
2. 28 Texas Administrative Code §19.2010 sets out requirements prior to issuing adverse determinations.
3. 28 Texas Administrative Code §133.240 sets out provisions regarding medical payments and denials.
4. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
5. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
6. 28 Texas Administrative Code §134.600 sets out sets out rules regarding preauthorization of health care.
7. 28 Texas Administrative Code §137.1 sets out general provisions related to the Disability Management concept.
8. 28 Texas Administrative Code §137.100 sets out the Division's Treatment Guidelines.

9. Texas Labor Code §408.021 entitles an injured employee to receive all reasonably required health care.
10. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 56 – SIGNIFICANT, SEPARATELY IDENTIFIABLE E/M SERVICE RENDERED.
    - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
    - 119 – BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED.
    - 168 – BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES.
    - 247 – A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE.
    - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
    - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
    - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.
    - 1115 – WE FIND THE ORIGINAL REVIEW TO BE ACCURATE AND ARE UNABLE TO RECOMMEND ANY ADDITIONAL ALLOWANCE.

Issues

1. Did the disputed services exceed a benefit maximum for the time period or occurrence?
2. Are the billed charges greater than the maximum unit value or daily maximum allowance for physical therapy services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 119 – "BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED." Per Texas Labor Code §408.021(a), "An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed." The respondent did not present documentation to support that a benefit maximum had been exceeded. Medical necessity is not in dispute. This denial reason is not supported.

2. The insurance carrier denied disputed services with claim adjustment reason code 168 – "BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES." The respondent's position statement asserts, "Our investigation has found that reimbursement was reduced or denied as per Medicare Guidelines there is a 60 minute maximum allowed for constant attendance modalities and therapeutic codes." The respondent did not present any documentation to support this Medicare policy.

   Regardless, 28 Texas Administrative Code §134.203(a)(7) requires that "Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program." Additionally, 28 Texas Administrative Code§137.1(c) states that "The Division will utilize this chapter to implement and interpret specific provisions contained in Labor Code §413.011(a) and (e), and this chapter takes precedence over any conflicting payment policy provisions adopted or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program." Chapter 137 includes the Division's Treatment Guidelines in §137.100, which adopts by reference the *Official Disability Guidelines - Treatment in Workers' Comp,* excluding the return to work pathways, (ODG), published by Work Loss Data Institute. As the division has adopted treatment guidelines that conflict with such a Medicare payment policy, the Division rules and Treatment Guidelines take precedence and that Medicare policy is not applicable to the services in this dispute.

   The respondent further states, in a supplementary response to the Division:

   > Per TAC 133.100, physical therapy is required to be based on the ODG guidelines and the preauthorization of treatment guideline protocols for the injury. The 60 minute limitation rule is based on the general rule within ODG for physical therapy visits. The general rule is that each session should be limited to four modalities/procedures and the total length of each session to be 45-60 minutes. Additional time and treatment procedures are based on the documentation submitted to substantiate the medical necessity of the additional treatment and/or preauthorization for the additional treatment.

While the respondent has paraphrased a select portion of the preface to the Official Disability Guidelines, the full text of the relevant paragraph states:

> Generally there should be no more than 4 modalities/procedural units in total per visit, allowing the PT visit to focus on those treatments where there is evidence of functional improvement, and limiting the total length of each PT visit to 45-60 minutes unless additional circumstances exist requiring extended length of treatment. Treatment times per session may vary based upon the patient's medical presentation but typically may be 45-60 minutes in order to provide full, optimal care to the patient. Additional time may be required for the more complex and slow to respond patients. While an average of 3 or 4 modalities/ procedural units per visit reflect the typical number of units, this is not intended to limit or cap the number of units that are medically necessary for a particular patient, for example, in unusual cases where co-morbidities involve completely separate body domains, but documentation should support an average greater than 4 units per visit. These additional units should be reviewed for medical necessity, and authorized if determined to be medically appropriate for the individual injured worker.

The full text makes clear that the "While an average of 3 or 4 modalities/ procedural units per visit reflect the typical number of units, this is not intended to limit or cap the number of units that are medically necessary for a particular patient . . . These additional units should be reviewed for medical necessity, and authorized if determined to be medically appropriate for the individual injured worker. " However, the insurance carrier failed to present documentation to support that it ever prospectively or retrospectively reviewed the medical necessity of the disputed services.

The requestor presented documentation to support that they requested preauthorization for eight units of therapeutic procedures per visit. However, the insurance carrier responded that authorization was not needed for the first 6 visits of physical therapy—a response that was not correct, as the insurance carrier later asserted a denial that it now characterizes as for exceeding the Division's Treatment Guidelines. Although 28 Texas Administrative Code §134.600(p)(5)(C) may exempt the first six visits of therapy, §134.600(p)(12) still requires preauthorization for "treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier." Therefore, it was an inappropriate response that authorization was not needed.

28 Texas Administrative Code §134.600(g)(3) requires that "If denying the request, the insurance carrier shall indicate whether it is issuing an adverse determination, and/or whether the denial is based on an unrelated injury or diagnosis in accordance with subsection (m) of this section." The insurance carrier did not present documentation to support that the request for preauthorization had been submitted to utilization review for prospective review of medical necessity.

Subsection (j) further requires that:

> The insurance carrier shall send written notification of the approval of the request, adverse determination on the request, or denial of the request under subsection (g) of this section because of an unrelated injury or diagnosis within one working day of the decision to the:
> (1) injured employee;
> (2) injured employee's representative; and
> (3) requestor, if not previously sent by facsimile or electronic transmission.

No documentation was presented to support the insurance carrier sent written notification of the adverse determination in accordance with subsection (j).

Nor does the submitted documentation support that the insurance carrier made any adverse determination in accordance with §134.600(a)(1), which requires "A determination by a utilization review agent made on behalf of a payor that the health care services provided or proposed to be provided to an injured employee are not medically necessary or appropriate."

No documentation was presented to support that the insurance carrier met the notice and reasonable opportunity requirements of §134.600(m), which requires that:

> In accordance with §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination), the insurance carrier shall afford the requestor a reasonable opportunity to discuss the

> clinical basis for the adverse determination prior to issuing the adverse determination. The notice of adverse determination must comply with the requirements of §19.2009

While the documentation supports that the health care provider requested preauthorization, because the health care provider did not actually obtain preauthorization for the disputed services—the services were then still subject to retrospective medical necessity review at the time of bill processing. However, the insurance carrier did not avail itself of the opportunity to perform a retrospective medical necessity review of the disputed services during the bill review process, and did not issue a denial based on such a review.

Per 28 Texas Administrative Code §133.240(p):

> all utilization review must be performed by an insurance carrier that is registered with or a utilization review agent that is certified by the Texas Department of Insurance to perform utilization review in accordance with Insurance Code, Chapter 4201 and Chapter 19 of this title.

Additionally, subsection §133.240(q) requires that:

> When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title (relating to Notice of Determinations Made in Utilization Review). Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination), including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care

No documentation was presented to support that the insurance carrier met the requirements of §133.240(p) or (q) during the bill review process. The respondent has therefore waived the right to raise any issues regarding the medical necessity of the disputed services.

Moreover, no documentation was found to support that the insurance carrier ever presented a denial reason to the requestor related to the sufficiency of medical documentation prior to the filing of a medical fee dispute—as required by §133.307(d)(2)(F), which requires that:

> The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

Consequently, the requestor has waived the right to raise such new defenses or denial reasons during medical fee dispute resolution.

For the above reasons, the Division concludes that the respondent has failed to support denial reason code 168 – "BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES." The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that "To determine the MAR [Maximum Allowable Reimbursement] 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 $52.83 . . . (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." The applicable Division conversion factor for calendar year 2013 is $55.30. Reimbursement is calculated as follows:

- Procedure code 97140, service date November 21, 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 is 0.43. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.979 is 0.43076. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.86902 is multiplied by the Division conversion factor of $55.30 for a MAR of $48.06. 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 subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $36.15 at 2 units is $72.30.

- Procedure code 97112, service date November 21, 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 is 0.45. The practice expense (PE) RVU of 0.52 multiplied by the PE GPCI of 0.979 is 0.50908. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.96734 is multiplied by the Division conversion factor of $55.30 for a MAR of $53.49. 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 subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $53.49. The PE reduced rate is $39.42. The total is $92.91.
- Procedure code 97110, service date November 21, 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 is 0.45. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 0.979 is 0.46992. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.92818 is multiplied by the Division conversion factor of $55.30 for a MAR of $51.33. 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 subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $38.34 at 4 units is $153.36.
- Procedure code 99213, service date November 25, 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 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.97. The practice expense (PE) RVU of 1.1 multiplied by the PE GPCI of 0.979 is 1.0769. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.826 is 0.05782. The sum of 2.10472 is multiplied by the Division conversion factor of $55.30 for a MAR of $116.39.
- Procedure code 99080, service date November 25, 2013, has a status indicator of B, which denotes a bundled code. Payments for these services are bundled into the payment for other services to which they are incident.
- Procedure code 97140, service date November 25, 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 is 0.43. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.979 is 0.43076. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.86902 is multiplied by the Division conversion factor of $55.30 for a MAR of $48.06. 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 subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $36.15 at 2 units is $72.30.

- Procedure code 97112, service date November 25, 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 is 0.45. The practice expense (PE) RVU of 0.52 multiplied by the PE GPCI of 0.979 is 0.50908. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.96734 is multiplied by the Division conversion factor of $55.30 for a MAR of $53.49. 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 subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $53.49. The PE reduced rate is $39.42. The total is $92.91.
- Procedure code 97110, service date November 25, 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 is 0.45. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 0.979 is 0.46992. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.92818 is multiplied by the Division conversion factor of $55.30 for a MAR of $51.33. 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 subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $38.34 at 4 units is $153.36.

4. The total allowable reimbursement for the services in dispute is $753.53. This amount less the amount previously paid by the insurance carrier of $550.67 leaves an amount due to the requestor of $202.86. 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 $202.86.

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 $202.86 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	October 16, 2015
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, 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 MFDR 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.