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
Elite Healthcare Fort Worth

Respondent Name
Commerce & Industry Insurance

MFDR Tracking Number
M4-15-3429-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 15, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier did not pay according to the Medicare Fee Schedule for 2014 and 2015."

Amount in Dispute: $85.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the EOB provided by the Requestor shows reimbursement was per the DWC fee schedule, and that the reduction was due to the Requestor not documenting services that extended beyond the 30 to 45 minute time period."

Response Submitted by: AIG, P.O. Box 25974, Shawnee Mission, KS 66225

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 3, 2015	Physical Therapy Services	$85.04	$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. 203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – Workers compensation jurisdictional fee schedule adjustment

- 2 – The charge for the procedure exceeds the amount indicated in the fee schedule
- 4 – The usual treatment session provided in the home or office setting is 30 to 45 minutes. The medical necessity of services for an unusual length of time must be documented.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 4 – "The usual treatment session provided in the home or office setting is 30 to 45 minutes. The medical necessity of service for an unusual length of time must be documented." 28 Texas Administrative Code §134.600 (p) states in pertinent part that, Non-emergency health care requiring preauthorization includes:

    (5) Physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

    (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

    (i) Modalities, both supervised and constant attendance;

    Review of the submitted information finds;

    a. The services in dispute were reviewed by HDi or Health Direct, Inc, on November 6, 2014
    b. The Units/Days Certified: 10
    c. Procedure/Treatment: 10 visits physical therapy Body Part: Bilateral shoulders, Cervical spine
    d. Utilization Review Department states, "This treatment has been recommended as medically necessary…"

    The services in dispute were authorized per visit. No limits were found for number of treatments or time of treatments as found on the Explanation of Benefits. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.203 (c) states in pertinent part, "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 (date of service yearly conversion factor).

    The maximum allowable reimbursement is calculated as follows;

    - Procedure code 97140, service date February 3, 2015. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.005 is 0.43215. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 0.995 is 0.398. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 0.83787 is multiplied by the Division conversion factor of $56.20 for a MAR of $47.09. 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 $35.90 at 2 units is $71.80.
    - Procedure code 97112, service date February 3, 2015. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.005 is 0.45225. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 0.995 is 0.4776. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 0.93757 is multiplied by the

Division conversion factor of $56.20 for a MAR of $52.69. 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 $52.69. The PE reduced rate is $39.27. The total is $91.96.

- Procedure code 97110, service date February 3, 2015. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.005 is 0.45225. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.995 is 0.4378. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.772 is 0.01544. The sum of 0.90549 is multiplied by the Division conversion factor of $56.20 for a MAR of $50.89. 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 $38.59 at 4 units is $154.36.

3. The total allowable reimbursement for the services in dispute is $318.12. This amount less the amount previously paid by the insurance carrier of $318.12 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

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 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

		July 28, 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.