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
PHYTEX REHABILITATION LLC

MFDR Tracking Number
M4-18-0223-01

MFDR Date Received
September 25, 2017

Respondent Name
FACILITY INSURANCE CORP

Carrier's Austin Representative
Box Number 15

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have never received payment for these DOS. They originally denied for no authorization. Retro-authorization has been obtained, and is attached."

Amount in Dispute: $843.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider appears to have request pre-authorization on January 31, 2017 for services that had already been provided on December 21, 2016, December 30, 2016 and January 3, 2017. A group called Unimed Direct issued a determination report on February 1, 2017. However, as previously noted, that determination date as well as the request date were well after the services in question were provided. Accordingly, the carrier denied the services on the basis that preauthorization had not been obtained. The services in question required preauthorization."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
December 21, 2016 through January 3, 2017	97110, 97530 and 97010	$843.00	$473.70

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 preauthorization, concurrent review, and voluntary certification of healthcare.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197- Precertification/authorization/notification absent.
   - 240 – Pre-authorization not obtained.

Issues

1. Did the requestor obtain preauthorization for the disputed physical therapy services?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed for physical therapy services rendered on December 21, 2016 through January 3, 2017. The insurance carrier states in pertinent part, "...the carrier denied the services on the basis that preauthorization had not been obtained. The services in question required preauthorization." The requestor states in pertinent part, "They originally denied for no authorization. Retro-authorization has been obtained, and is attached."

   The insurance carrier denied the disputed services with denial reduction code "197- Precertification/authorization/ notification absent" and "240 – Pre-authorization not obtained."

   28 Texas Administrative Code §134.600(p) (5) states in pertinent part, "(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; (ii) Therapeutic procedures, excluding work hardening and work conditioning..."

   Review of the submitted documentation finds the following:

   The requestor obtained preauthorization for physical therapy services on January 31, 2017 to be rendered between 12/14/2016 through 01/30/2017, authorization issued on February 1, 2017 by UniMed Direct. The authorization letter identifies the request as "Review Level and Type: Initial Retro UR."

   The Division finds that the disputed physical therapy services required preauthorization; however the requestor submitted sufficient documentation to support that the utilization review agent for the carrier, UniMed Direct authorized and approved the service in dispute retrospectively. As a result, the requestor is entitled to reimbursement for the disputed services.

2. 28 Texas Administrative Code §134.203 states in pertinent part, "(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 $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (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..."

   Procedure code 97110, service date December 21, 2016, is a professional service paid per Rule §134.203(c). For this code, 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 0.44 multiplied by the PE GPCI of 0.92 is 0.4048. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.822 is 0.01644. The sum of 0.87124 is multiplied by the division conversion factor of $56.82 for a MAR of $49.50. Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $38.00 at 2 units is $76.00.

   Procedure code 97530, service date December 21, 2016, is a professional service paid per Rule §134.203(c). For this code, the relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.44. The practice expense (PE) RVU of 0.53 multiplied by the PE GPCI of 0.92 is 0.4876. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.822 is 0.00822. The sum of 0.93582 is multiplied by the division conversion factor of $56.82 for a MAR of $53.17. Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code has the highest PE for this date. The first unit is paid at $53.17. The PE reduced rate is $39.32. The total is $92.49.

   Procedure code 97010, service date December 21, 2016, has status indicator B, denoting a bundled code. Reimbursement is included with payment for other services to which this code is incident.

   Procedure code 97110, service date December 30, 2016, is a professional service paid per Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $38.00 at 2 units is $76.00.

   Procedure code 97530, service date December 30, 2016, is a professional service paid per Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code has the highest PE for this date. The first unit is paid at $53.17.

Procedure code 97010, service date December 30, 2016, has status indicator B, denoting a bundled code. Reimbursement is included with payment for other services to which this code is incident.

Procedure code 97530, January 3, 2017, is a professional service paid per Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code has the highest PE for this date. The first unit is paid at $54.61. The PE reduced rate is $40.19. The total is $94.80.

Procedure code 97110, January 3, 2017, is a professional service paid per Rule §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is billed, full payment is made for the first unit of the code with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $38.82 at 2 units is $77.64.

Procedure code 97010, January 3, 2017, has status indicator B, denoting a bundled code. Reimbursement is included with payment for other services to which this code is incident.

3. Review of the submitted documentation finds that the requestor is entitled to a total recommended amount of $473.70. Therefore, 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 $ $473.70.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $473.70, 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	November 10, 2017 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.