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
ERIC A VANDERWERFF, DC

Respondent Name
PROPERTY & CASUALTY INSURANCE COMPANY OF HARTFORD

MFDR Tracking Number
M4-18-0420-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 17, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "ALL of the carrier's denial codes are non-specific, generic denials, that are 100% IRRELEVANT to the charges. . . . On those pre-authorization letters, you will notice that Hartford admits that they authorized up to four modalities per session. Chiropractic manipulation is NOT considered a modality: it is a primary care procedure that includes an E&M service, and does NOT require pre-authorization for that reason."

Amount in Dispute: $2,165.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Physical and Occupational Therapy Specialty Guide — Part B developed by Novitas Solutions . . . recommends the normal PT session time at 45-60 minutes. The 45-60 minute per session for physical therapy is also based on ODG's general physical therapy treatment protocol. . . . Also our review finds that the billing units do not correspond with the medical documentation."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 10, 2016 to November 3, 2016	Professional Medical Services	$2,165.57	$556.60

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 fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
4. Texas Labor Code §408.021 entitles an injured employee to all required health care as and when needed.
5. Insurance Code Subchapter U sets out requirements for utilization review of health care provided under workers' compensation insurance coverage

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 86 – SERVICE PERFORMED WAS DISTINCT OR INDEPENDENT FROM OTHER SERVICES PERFORMED ON THE SAME DAY.
   - 119 – BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
   - 163 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE UNIT VALUE AND/OR MULTIPLE PROCEDURE RULES
   - 168 – BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES
   - 309 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
   - 5359 - WE ARE UNABLE TO PROCESS YOUR RE-BILLING, AS THE DOCUMENTATION DOES NOT SPECIFY THE CONCERN REGARDING THE ORIGINAL ANALYSIS. PLEASE RE-SUBMIT WITH A COPY OF THE ORIGINAL EOR AND A CLARIFICATION FOR THE BASIS OF THE RECONSIDERATION.
   - 247 – A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 1115 - WE FIND THE ORIGINAL REVIEW TO BE ACCURATE AND ARE UNABLE TO RECOMMEND ANY ADDITIONAL ALLOWANCE.

Issues

1. Has the requestor waived the right to medical fee dispute resolution for failure to timely file the MFDR request?
2. Are the disputed services or the injured employee subject to a benefit maximum?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) requires a requestor timely file the request for medical fee dispute resolution (MFDR) with the division's MFDR Section or waive the right to MFDR.

   Rule §133.307(c)(1)(A) further requires a request for MFDR that does not meet any exceptions listed in Rule §133.307(c)(1)(B), be filed no later than one year after the dates of service in dispute.

   The disputed dates of service extend from October 10, 2016 to November 3, 2016. The MFDR request was received in the division's MFDR Section on October 17, 2017. This date is later than one year after disputed dates of service October 10, 2016 and October 13, 2016.

   Review of the submitted information finds the services do not involve issues identified in Rule §133.307(c)(1)(B). Consequently, the MFDR request for dates of service October 10, 2016 and October 13, 2016 was not timely filed with the division. The requestor has thus waived the right to MFDR for these services.

   However, the requestor timely filed the MFDR request for dates of service from October 19, 2016 to November 3, 2016. Accordingly, these services are eligible for review.

2. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 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.

   The respondent asserts:

   > The Physical and Occupational Therapy Specialty Guide — Part B developed by Novitas Solutions . . . recommends the normal PT session time at 45-60 minutes. The 45-60 minute per session for physical therapy is also based on ODG's general physical therapy treatment protocol.

   Rule §134.203(c) requires that to determine the MAR for professional services, system participants shall apply Medicare payment policies with minimal modifications.

Rule §134.203(b)(1) further requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers . . . and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

Rule §134.203(a)(5) defines "Medicare payment policies" to 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.

Rule §134.203(a)(6) provides that, notwithstanding Medicare payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act.

The respondent asserts Novitas Solutions, the Medicare Administrative Contractor (MAC) for Texas, has adopted recommendations regarding the maximum time for physical therapy sessions. However, the division takes notice that this is not a *Medicare* payment policy, or a policy promulgated by CMS.

Novitas is a private company under contract with CMS to process Medicare claims. The division has not adopted local carrier determinations (LCDs) or payment policies of third-party contractors administering Medicare claims. LCDs are not published in the *Federal Register* or in the *Medicare Claims Processing Manual*, nor are such carrier interpretations of CMS rules required to be consistent between contractors or regions. An LCD made by a MAC can thus only be considered as advisory or illustrative when such policies do not originate from Medicare or CMS itself.

The division notes also that while Texas has adopted Medicare payment policies to determine reimbursement, Texas has not adopted Medicare's *benefits* or *coverage* policies, which, though appropriate for the retired, elderly and disabled populations Medicare serves, do not fit the needs of Texas injured employees.

Texas Labor Code §408.021(a) states, "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."

Further, Rule §134.203(a)(7) requires that specific provisions contained in the Texas Labor Code or division rules shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program.

Texas has adopted specific provisions regarding preauthorization and concurrent review of health care as found in Rule §134.600, as well as Insurance Code Subchapter U regarding utilization review of health care provided under workers' compensation insurance coverage — in addition to the broad medical benefit entitlement established under Labor Code §408.021. Such Texas provisions take precedence over any CMS policies regarding benefit or coverage limitations applicable to Medicare patients.

The respondent argues further, "The 45-60 minute per session for physical therapy is also based on ODG's general physical therapy treatment protocol." However, review of division treatment guidelines in effect on the disputed service dates for the employee's shoulder injury finds chiropractic manipulation and physical therapy are both recommended as treatment. Contrary to the respondent's assertions, no mention was found in the applicable guidelines referring to a time limit or daily benefit maximum for physical therapy — nor did the respondent provide any documentation to support this assertion.

The division notes also that Rule §134.600(c)(1)(B) states the insurance carrier is liable for all reasonable and necessary medical costs when preauthorization of any health care listed in subsection (p) was approved. Rule §134.600(p)(12) specifically lists those services that exceed or are not addressed by division treatment guidelines as requiring preauthorization. Therefore, if the provider seeks preauthorization for such services and the carrier approves, that authorization supersedes the division treatment guideline recommendations. The carrier is thus liable for payment of those services it has preauthorized.

Documentation was found to support preauthorization of chiropractic physiotherapy "with up to 4 modalities per each session." The following codes were specifically listed as authorized: chiropractic manipulation 98943; therapeutic procedures 97140 and 97110; and physical modality code G0283. The carrier authorized 8 sessions from September 30, 2016 to November 30, 2016.

While the carrier authorized "up to 4 modalities per each session," only one modality code is mentioned in the authorization approval and on the bills. The division notes that the physical therapy "modality" code range extends from CPT 97010 to 97039, with certain additional modalities designated by CMS requiring providers to bill CMS-assigned HCPCS codes, such as code G0283 (electrical stimulation) — the only code billed by the health care provider that is defined as a "modality."

Modalities are defined in the CPT Code Manual as "any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic light, mechanical or electric energy."

The division notes preauthorized CPT codes 97140 and 97110 are not *modalitie*s, but *therapeutic procedures* (defined in the CPT Manual as applying clinical skills and/or services that attempt to improve function); whereas, CPT 98943 is instead found in the *chiropractic manipulative treatment* range of CPT codes.

The preauthorization does not refer to any specific daily time limits or unit maximums for the services authorized. While the authorization mentions "up to 4 modalities per each session," it does not specify a time limit or unit limit on whatever modalities are performed.

The division concludes the provider did not exceed the authorized 4 modalities per session; nor did the carrier support any time or unit limit, daily allowance or benefit maximum applicable to the services. The above denial reasons are not supported. The services will thus be reviewed in accordance with division rules and fee guidelines.

3. This dispute regards medical services with reimbursement subject to the *Medical Fee Guideline for Professional Services*, 28 Texas Administrative Code §134.203, requiring the maximum allowable reimbursement (MAR) be determined by applying Medicare payment policies with modifications set out in the rule. The Medicare fee is the sum of geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The DWC conversion factor is substituted to calculate the MAR. The 2016 DWC conversion factor is $56.82.

   Per Medicare policy, when more than one unit is billed of therapy services designated by multiple-procedure payment indicator '5', the first unit of the therapy with the highest practice expense for that day is paid in full. Payment is reduced by 50% of the practice expense (PE) for each extra therapy unit performed on that date.

   Reimbursement is calculated as follows:

   October 19, 2016

   - Procedure code **G0283** has a Work RVU of 0.18 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.18324. The PE RVU of 0.2 multiplied by the PE GPCI of 1.009 is 0.2018. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 0.39276 is multiplied by the DWC conversion factor of $56.82 for a MAR of $22.32. For each extra therapy unit after the first unit of the code with the highest PE on that date, payment is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is **$16.58**.
   - Procedure code **97110** has a Work RVU of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.4581. The PE RVU of 0.44 multiplied by the PE GPCI of 1.009 is 0.44396. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.772 is 0.01544. The sum of 0.9175 is multiplied by the DWC conversion factor of $56.82 for a MAR of $52.13. For each extra therapy unit after the first unit of the code with the highest PE on that date, payment is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $39.52 at 4 units is **$158.08**.
   - Procedure code **97140** has a Work RVU of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.43774. The PE RVU of 0.4 multiplied by the PE GPCI of 1.009 is 0.4036. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 0.84906 is multiplied by the DWC conversion factor of $56.82 for a MAR of $48.24. For each extra therapy unit after the first unit of the code with the highest PE on that date, payment is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $36.78 at 2 units is **$73.56**.
   - Procedure code **98943** has a Work RVU of 0.46 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.46828. The PE RVU of 0.28 multiplied by the PE GPCI of 1.009 is 0.28252. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.772 is 0.02316. The sum of 0.77396 is multiplied by the DWC conversion factor of $56.82 for a MAR of **$43.98**.

October 24, 2016

- Procedure code **G0283** has a Work RVU of 0.18 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.18324. The PE RVU of 0.2 multiplied by the PE GPCI of 1.009 is 0.2018. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 0.39276 is multiplied by the DWC conversion factor of $56.82 for a MAR of $22.32. For each extra therapy unit after the first unit of the code with the highest PE on that date, payment is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is **$16.58**.
- Procedure code **97110** has a Work RVU of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.4581. The PE RVU of 0.44 multiplied by the PE GPCI of 1.009 is 0.44396. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.772 is 0.01544. The sum of 0.9175 is multiplied by the DWC conversion factor of $56.82 for a MAR of $52.13. For each extra therapy unit after the first unit of the code with the highest PE on that date, payment is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $39.52 at 4 units is **$158.08**.
- Procedure code **97140** has a Work RVU of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.43774. The PE RVU of 0.4 multiplied by the PE GPCI of 1.009 is 0.4036. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 0.84906 is multiplied by the DWC conversion factor of $56.82 for a MAR of $48.24. For each extra therapy unit after the first unit of the code with the highest PE on that date, payment is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $36.78 at 2 units is **$73.56**.

October 26, 2016

- Procedure code **G0283** has a Work RVU of 0.18 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.18324. The PE RVU of 0.2 multiplied by the PE GPCI of 1.009 is 0.2018. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 0.39276 is multiplied by the DWC conversion factor of $56.82 for a MAR of $22.32. For each extra therapy unit after the first unit of the code with the highest PE on that date, payment is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is **$16.58**.
- Procedure code **97110** has a Work RVU of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.4581. The PE RVU of 0.44 multiplied by the PE GPCI of 1.009 is 0.44396. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.772 is 0.01544. The sum of 0.9175 is multiplied by the DWC conversion factor of $56.82 for a MAR of $52.13. For each extra therapy unit after the first unit of the code with the highest PE on that date, payment is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $39.52 at 4 units is **$158.08**.
- Procedure code **97140** has a Work RVU of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.43774. The PE RVU of 0.4 multiplied by the PE GPCI of 1.009 is 0.4036. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 0.84906 is multiplied by the DWC conversion factor of $56.82 for a MAR of $48.24. For each extra therapy unit after the first unit of the code with the highest PE on that date, payment is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $36.78 at 2 units is **$73.56**.
- Procedure code **98943** has a Work RVU of 0.46 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.46828. The PE RVU of 0.28 multiplied by the PE GPCI of 1.009 is 0.28252. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.772 is 0.02316. The sum of 0.77396 is multiplied by the DWC conversion factor of $56.82 for a MAR of **$43.98**.

October 27, 2016

- Note: the requestor listed this code as 98943 on the **DWC060** request form *Table of Disputed Services*, whereas the code that was billed (and paid) was 98941. The division hereby takes notice that code 98943 as listed on the requestor's table was a typographical error and will deem the code in dispute to be the code as billed, 98941. Procedure code **98941** has a Work RVU of 0.71 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.72278. The PE RVU of 0.42 multiplied by the PE GPCI of 1.009 is 0.42378. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.772 is 0.01544. The sum of 1.162 is multiplied by the DWC conversion factor of $56.82 for a MAR of **$66.02**.

- Procedure code **G0283** has a Work RVU of 0.18 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.18324. The PE RVU of 0.2 multiplied by the PE GPCI of 1.009 is 0.2018. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 0.39276 is multiplied by the DWC conversion factor of $56.82 for a MAR of $22.32. For each extra therapy unit after the first unit of the code with the highest PE on that date, payment is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is **$16.58**.
- Procedure code **97110** has a Work RVU of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.4581. The PE RVU of 0.44 multiplied by the PE GPCI of 1.009 is 0.44396. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.772 is 0.01544. The sum of 0.9175 is multiplied by the DWC conversion factor of $56.82 for a MAR of $52.13. For each extra therapy unit after the first unit of the code with the highest PE, payment is reduced by 50% of the practice expense. This code has the highest PE for this date. The first unit is paid at $52.13. The PE reduced rate is $39.52 at 3 units is $118.56. The total is **$170.69**.
- Per Medicare policy regarding correct coding initiative (CCI) edits, procedure code **97140** may not be reported with code 98941 billed on this same date. A modifier is allowed to differentiate the services. Separate payment may be justified if an appropriate modifier is reported. Although the provider billed the code with modifier 59, review of the submitted medical records finds the services were administered in the same encounter at the same anatomical location. The documentation did not sufficiently distinguish, nor did the provider explain, how the services were separate. Based on the submitted information, modifier 59 is not supported. Reimbursement for this service is included in the payment for code 98941. Separate payment is not recommended.

November 2, 2016

- Note: the requestor listed this code as 98943 on the **DWC060** request form *Table of Disputed Services*, whereas the code that was billed (and paid) was 98941. The division hereby takes notice that code 98943 as listed on the requestor's table was a typographical error and will deem the code in dispute to be the code as billed, 98941. Procedure code **98941** has a Work RVU of 0.71 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.72278. The PE RVU of 0.42 multiplied by the PE GPCI of 1.009 is 0.42378. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.772 is 0.01544. The sum of 1.162 is multiplied by the DWC conversion factor of $56.82 for a MAR of **$66.02**.
- Procedure code **G0283** has a Work RVU of 0.18 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.18324. The PE RVU of 0.2 multiplied by the PE GPCI of 1.009 is 0.2018. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 0.39276 is multiplied by the DWC conversion factor of $56.82 for a MAR of $22.32. For each extra therapy unit after the first unit of the code with the highest PE on that date, payment is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is **$16.58**.
- Procedure code **97110** has a Work RVU of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.4581. The PE RVU of 0.44 multiplied by the PE GPCI of 1.009 is 0.44396. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.772 is 0.01544. The sum of 0.9175 is multiplied by the DWC conversion factor of $56.82 for a MAR of $52.13. For each extra therapy unit after the first unit of the code with the highest PE, payment is reduced by 50% of the practice expense. This code has the highest PE for this date. The first unit is paid at $52.13. The PE reduced rate is $39.52 at 3 units is $118.56. The total is **$170.69**.
- Per Medicare policy regarding correct coding initiative (CCI) edits, procedure code **97140** may not be reported with code 98941 billed on this same date. A modifier is allowed to differentiate the services. Separate payment may be justified if an appropriate modifier is reported. Although the provider billed the code with modifier 59, review of the submitted medical records finds the services were administered in the same encounter at the same anatomical location. The documentation did not sufficiently distinguish, nor did the provider explain, how the services were separate. Based on the submitted information, modifier 59 is not supported. Reimbursement for this service is included in the payment for code 98941. Separate payment is not recommended.

November 3, 2016

- Procedure code **G0283** has a Work RVU of 0.18 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.18324. The PE RVU of 0.2 multiplied by the PE GPCI of 1.009 is 0.2018. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 0.39276 is multiplied by the DWC conversion factor of $56.82 for a MAR of $22.32. For each extra therapy unit after the first, payment is reduced by 50% of the practice expense. This code does not have the highest PE. The PE reduced rate is **$16.58**.
- Procedure code **97110** has a Work RVU of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.4581. The PE RVU of 0.44 multiplied by the PE GPCI of 1.009 is 0.44396. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.772 is 0.01544. The sum of 0.9175 is multiplied by the DWC conversion factor of $56.82 for a MAR of $52.13. For each extra therapy unit after the first unit of the code with the highest PE on that date, payment is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $39.52 at 4 units is **$158.08**.
- Procedure code **97140** has a Work RVU of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.43774. The PE RVU of 0.4 multiplied by the PE GPCI of 1.009 is 0.4036. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 0.84906 is multiplied by the DWC conversion factor of $56.82 for a MAR of $48.24. For each extra therapy unit after the first unit of the code with the highest PE on that date, payment is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is $36.78 at 2 units is **$73.56**.
- The requestor also listed code **98943** as in dispute for November 3, 2018 on the **DWC060** request form *Table of Disputed Services*; however, the provider did not bill code 98943 or any other similar procedure on this date. Procedure code 98943 is not supported. No payment is recommended.

4. The total recommended reimbursement for the services in dispute is $1,587.42. The submitted documentation supports the insurance carrier paid $1,030.82 for the above disputed services, leaving an amount due to the requestor of $556.60. This amount is recommended.

Conclusion

For the reasons stated above, the division finds the requestor has established that additional reimbursement is due. As a result, the amount ordered is $556.60.

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 $556.60, 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 26, 2018
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 Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.