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
Blue Lagune Therapy Inc

Respondent Name
Travelers Property Casualty Company of America

MFDR Tracking Number
M4-18-4778-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
August 6, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Based on DWCC guidelines, for physical therapy, the medical necessity prevails over any limitation set by Medicare. Since the authorization approved the services as medically necessary and did not set any limitation guidelines under the authorization, the physical therapy was performed based on the medical necessity."

Amount in Dispute: $1,100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the documentation and determined the Provider was properly reimbursed under the applicable Division fee schedule. The Provider is not entitled to additional reimbursement for the disputed services."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 22 – 24, 2018	97113	$1,100.00	$435.86

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 §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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B15 – This procedure code requires a functional reporting G code to be billed

- 119 – Benefit Maximum for this time period or occurrence has been reached
- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

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

Findings

1. The requestor is seeking $1,100.00 for physical therapy services rendered from May 22 -24, 2018 in their clinic setting. The carrier reduced the submitted billed amounts as 119 – "Benefit maximum for this time period or occurrence has been reached," 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules" and 119 – "Benefit maximum for this time period or occurrence has been reached."

28 Texas Administrative Code §134.203 sets out the medical fee guideline for professional services and contains the following applicable rules.

> (a)(5) "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.
>
> (b) 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

Review of the Medicare Claims processing manual, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals, Chapter 5, 20.2, Section D. states,

> *Specific Limits for HCPCS*
>
> *The Deficit Reduction Act of 2005, section 5107 requires the implementation of clinically appropriate code edits to eliminate improper payments for outpatient therapy services. The following codes may be billed, when covered, only at or below the number of units indicated on the chart per treatment day. When higher amounts of units are billed than those indicated in the table below, the units on the claim line that exceed the limit shall be denied as medically unnecessary (according to 1862(a)(1)(A)).*

The codes in dispute 97113 and 97530 are not contained on this list. The denial 119 – "Benefit maximum for this time period or occurrence has been reached" and 168 – "Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services" is not supported.

The Medicare payment policy found at the above link, in Section 10.7 states,

> *For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 50 percent payment is made for the PE for services submitted on either professional or institutional claims.*
> *To determine which services will receive the MPPR, contractors shall rank services according to the applicable PE relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services.*

The carrier reduced the payment amounts with adjustment code 163 – "The charge for this procedure exceeds the unit value and/or the multiple procedure rules." This reduction is supported. This Medicare payment policy applied to the Division fee guideline is shown below. **All services billed on each date of service will be calculated to ensure correct application of the MPPR reduction**.

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).

   - Procedure code 97113 -GP, -59, billed May 22, 2018 for six units has a PE of 0.61 not the highest for this date and will be paid at the reduced rate of $28.15. 58.31/35.9996 x $28.15 x 6 = $273.57. Review of the "Physical Therapy Daily Note" dated May 22, 2018 supported the use of the 59 modifier as treatment was "separate and distinct."
   - Procedure code 97530 -GP, billed May 22, 2018 for three units has a PE of 0.69 and will be paid at the full reimbursement rate of $39.71 for the first unit and $28.06 for the second and third units. 58.31/35.9996 x $39.71 = $64.32. 58.31/35.9996 x $28.06 x 2 = $90.90. $64.32 + $90.90 = $155.22
   - Procedure code 97113 -GP, -59, billed May 24, 2018 for six units has a PE of 0.61 not the highest for this date and will be paid at the reduced rate of $28.15. 58.31/35.9996 x $28.15 x 6 = $273.57. Review of the "Physical Therapy Daily Note" dated May 24, 2018 supported the use of the 59 modifier as treatment was "separate and distinct."
   - Procedure code 97530 -GP, billed May 24, 2018 for three units has a PE of 0.69 and will be paid at the full reimbursement rate of $39.71 for the first unit and $28.06 for the second and third units. 58.31/35.9996 x $39.71 = $64.32. 58.31/35.9996 x $28.06 x 2 = $90.90. $64.32 + $90.90 = $155.22

3. The total allowable reimbursement for the services rendered is $857.58. The carrier previously paid $421.72 leaving a balance of $435.86 due to the health care provider. 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 $435.86.

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 $435.86, 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	October 10, 2018 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, 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 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. **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.