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
HARTFORD UNDERWRITERS INSURANCE COMPANY

MFDR Tracking Number
M4-18-4913-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 14, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As the attached authorization indicates that the services were approved and deemed as medically necessary. Based on DWC 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 base on medical necessity."

Amount in Dispute: $2,970.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services were processed in accordance with Texas Guidelines for physical therapy services."

Response Submitted by: the Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 12, 2018 to May 3, 2018	Physical Therapy: 97113	$2,970.00	$1,286.29

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. 28 Texas Administrative Code §137.100 sets out division treatment guidelines.
5. Labor Code §408.021 establishes an injured employee's entitlement to medical benefits.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 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
   - 86 – SERVICE PERFORMED WAS DISTINCT OR INDEPENDENT FROM OTHER SERVICES PERFORMED ON THE SAME DAY.
   - 168 – BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES
   - 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
   - 1001 - BASED ON THE CORRECTED BILLING AND/OR ADDITIONAL INFORMATION/DOCUMENTATION NOW SUBMITTED BY THE PROVIDER, WE ARE RECOMMENDING FURTHER PAYMENT TO BE MADE FOR THE ABOVE NOTED PROCEDURE CODE.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 18 – EXACT DUPLICATE CLAIM/SERVICE
   - 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.
   - 536 – THESE CHARGES HAVE ALREADY BEEN BILLED AND PAID FOR ACCORDING TO FEE SCHEDULE AND/OR REASONABLE GUIDELINES. NO FURTHER PAYMENT IS DUE.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 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

   28 Texas Administrative Code §134.203(b)(1) 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."

   However, Rule §134.203(a)(7) requires, "Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules . . . shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program."

   Texas Labor Code §408.021(a) provides that "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."

   While the division has adopted Medicare payment policies, with modifications as specified in division rules, the division has not adopted Medicare *benefit* policies. The Labor Code entitles injured employees to "all health care reasonably required by the nature of the injury *as and when needed*." The division has further adopted treatment guidelines and procedures for preauthorization of services and dispute of medical necessity that take precedence over any conflicting CMS provisions. Review of the division treatment guidelines finds no reference to a daily time limit or unit limit or any daily maximum allowance related to the disputed services.

   The insurance carrier did not present any information to support its denial reasons based on "benefit maximum" or "daily maximum allowance" for physical therapy or physical medicine services. Review of the submitted pre-authorization approval letter finds the disputed services were preauthorized. The letter did not contain any limitations with respect to daily maximum time limits or the number of units to be performed.

   The insurance carrier's denial reasons are not supported. The disputed services will therefore be reviewed for reimbursement in accordance with division rules and fee guidelines.

2. 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 the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The DWC conversion factor is substituted to calculate the MAR. The 2018 DWC conversion factor is $58.31.

   Reimbursement is calculated as follows:

   - Procedure code 97113, April 12, 2018, has a Work RVU of 0.48 multiplied by the Work GPCI of 1.02 is 0.4896. The practice expense (PE) RVU of 0.61 multiplied by the PE GPCI of 1.012 is 0.61732. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.936 is 0.01872. The sum is 1.12564 multiplied by the DWC conversion factor of $58.31 for a MAR of $65.64. For each extra therapy unit after the first unit of the code with the highest practice expense, payment is reduced by 50% of the practice expense. This code has the highest PE for this date. The first unit is paid at $65.64. The PE reduced rate is $47.64 at 5 units is $238.20. The total MAR for 6 units is $303.84.
   - Procedure code 97113, April 19, 2018, has a Work RVU of 0.48 multiplied by the Work GPCI of 1.02 is 0.4896. The PE RVU of 0.61 multiplied by the PE GPCI of 1.012 is 0.61732. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.936 is 0.01872. The sum is 1.12564 multiplied by the DWC conversion factor of $58.31 for a MAR of $65.64. The PE for this code is not the highest for this date; payment is reduced by 50% of the practice expense. The PE reduced rate is $47.64 at 6 units is $285.84.
   - Procedure code 97113, April 24, 2018, has a Work RVU of 0.48 multiplied by the Work GPCI of 1.02 is 0.4896. The PE RVU of 0.61 multiplied by the PE GPCI of 1.012 is 0.61732. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.936 is 0.01872. The sum is 1.12564 multiplied by the DWC conversion factor of $58.31 for a MAR of $65.64. The PE for this code is not the highest for this date; payment is reduced by 50% of the practice expense. The PE reduced rate is $47.64 at 6 units is $285.84.
   - Procedure code 97113, April 25, 2018, has a Work RVU of 0.48 multiplied by the Work GPCI of 1.02 is 0.4896. The PE RVU of 0.61 multiplied by the PE GPCI of 1.012 is 0.61732. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.936 is 0.01872. The sum is 1.12564 multiplied by the DWC conversion factor of $58.31 for a MAR of $65.64. The PE for this code is not the highest for this date; payment is reduced by 50% of the practice expense. The PE reduced rate is $47.64 at 6 units is $285.84.
   - Procedure code 97113, April 26, 2018, has a Work RVU of 0.48 multiplied by the Work GPCI of 1.02 is 0.4896. The PE RVU of 0.61 multiplied by the PE GPCI of 1.012 is 0.61732. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.936 is 0.01872. The sum is 1.12564 multiplied by the DWC conversion factor of $58.31 for a MAR of $65.64. The PE for this code is not the highest for this date; payment is reduced by 50% of the practice expense. The PE reduced rate is $47.64 at 6 units is $285.84.
   - Procedure code 97113, May 1, 2018, has a Work RVU of 0.48 multiplied by the Work GPCI of 1.02 is 0.4896. The PE RVU of 0.61 multiplied by the PE GPCI of 1.012 is 0.61732. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.936 is 0.01872. The sum is 1.12564 multiplied by the DWC conversion factor of $58.31 for a MAR of $65.64. The PE for this code is not the highest for this date; payment is reduced by 50% of the practice expense. The PE reduced rate is $47.64 at 6 units is $285.84.
   - Procedure code 97113, May 3, 2018, has a Work RVU of 0.48 multiplied by the Work GPCI of 1.02 is 0.4896. The PE RVU of 0.61 multiplied by the PE GPCI of 1.012 is 0.61732. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.936 is 0.01872. The sum is 1.12564 multiplied by the DWC conversion factor of $58.31 for a MAR of $65.64. The PE for this code is not the highest for this date; payment is reduced by 50% of the practice expense. The PE reduced rate is $47.64 at 6 units is $285.84.

3. The total allowable reimbursement for the services in dispute is $2,018.88. The insurance carrier has made payments of $589.67 and $142.92 toward the disputed line items, for a total payment of $732.59 for the disputed services. The amount remaining due to the requestor is $1,286.29. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

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 $1,286.29.

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 $1,286.29, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	September 7, 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.