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
Patient Care Injury Clinic

Respondent Name
Harris County

MFDR Tracking Number
M4-18-5010-01

Carrier's Austin Representative
Box Number 21

MFDR Date Received
August 16, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted our bills and clinical documentation in a timely fashion. We feel our facility should be paid according to the workers compensation fee schedule guidelines."

Amount in Dispute: $902.55

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent has paid for the number of units that were preauthorized, thus no further reimbursement is owed."

Response Submitted by: Thornton Biechlin Reynolds & Guerra

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 25, 2018 through July 7, 2018	Physical Therapy Services	$902.55	$562.70

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:
   - 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
   - 168 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Did the respondent raise a new issue?
2. Are the insurance carrier's reasons for reduction of payment supported?
3. What rule is applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states, "The bills submitted exceeded the preauthorization approval." Review of the submitted explanation of benefits a denial for lack of preauthorization or preauthorization exceeded was not presented to the requestor prior to the requestor prior to the request for MFDR. 28 Texas Administrative Code 133.307 (d) (F) states in pertinent part,

   > The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

   While the "Preauthorization Determination Letter" dated June 14, 2018 does state, "Generally there should be no more than 4 modalities/procedure units in total per visit…" No limit was placed for authorized codes 97110, 97112, or 97140. Therefore, this review will be based on the denials presented to the requestor prior to MFDR.

2. The requestor is seeking $902.55 for physical therapy services rendered from June 25, 2018 through July 7, 2018. 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 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 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, 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 two codes in dispute 97110 and 97140 are not found in this list. The denial for 168 – "Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services" and 119 - "Benefit maximum for this time period or occurrence has been reached" is not supported.

The denial 163 – "The charge for this procedure exceeds the unit value and/or the multiple procedure rules." 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.*

Based on the above, this reduction is supported. This Medicare payment policy applied to the Division fee guideline is shown below.

3. 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 MPPR ranking is applied to each service billed per date of service to determine the appropriate payment. The MAR is calculated as DWC conversion factor/Medicare conversion factor x Medicare allowable. This calculation based on the above is as follows:

   - Procedure code 97110, billed June 25, 2018, for 4 units has a PE of 0.4 not the highest for this date and will be paid at the reduced rate of $24.48. 58.31/35.9996 x $24.48 x 4 = $158.60
   - Procedure code 97140, billed June 25, 2018, for 2 units has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of $22.50. 58.31/35.9996 x $22.50 x 2 = $72.89
   - Procedure code 97112, billed June 25, 2018, has a PE of 0.47 the highest for this date and will be paid at the full allowable of $36.16. 58.31/35.9996 x $36.16 = $58.57
   - Procedure code G0283, billed June 25, 2018, has a PE of 0.23 not the highest for this date and will be paid at the reduced allowable of 11.14. 58.31/35.9996 x $11.14 = $18.04
   - Procedure code 97110, billed June 27, 2018, for 4 units has a PE of 0.4 not the highest for this date and will be paid at the reduced rate of $24.48. 58.31/35.9996 x $24.48 x 4 = $158.60
   - Procedure code 97140, billed June 27, 2018, for 2 units has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of $22.50. 58.31/35.9996 x $22.50 x 2 = $72.89
   - Procedure code 97112, billed June 27, 2018, has a PE of 0.47 the highest for this date and will be paid at the full allowable of $36.16. 58.31/35.9996 x $36.16 = $58.57
   - Procedure code G0283, billed June 27, 2018, has a PE of 0.23 not the highest for this date and will be paid at the reduced allowable of 11.14. 58.31/35.9996 x $11.14 = $18.04
   - Procedure code 97110, billed July 3, 2018, for 4 units has a PE of 0.4 not the highest for this date and will be paid at the reduced rate of $24.48. 58.31/35.9996 x $24.48 x 4 = $158.60
   - Procedure code 97140, billed July 3, 2018, for 2 units has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of $22.50. 58.31/35.9996 x $22.50 x 2 = $72.89

- Procedure code 97112, billed July 3, 2018, has a PE of 0.47 the highest for this date and will be paid at the full allowable of $36.16. 58.31/35.9996 x $36.16 = $58.57
- Procedure code G0283, billed July 3, 2018, has a PE of 0.23 not the highest for this date and will be paid at the reduced allowable of 11.14. 58.31/35.9996 x $11.14 = $18.04
- Procedure code 97110, billed July 5, 2018, for 4 units has a PE of 0.4 not the highest for this date and will be paid at the reduced rate of $24.48. 58.31/35.9996 x $24.48 x 4 = $158.60
- Procedure code 97140, billed July 5, 2018, for 2 units has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of $22.50. 58.31/35.9996 x $22.50 x 2 = $72.89
- Procedure code 97112, billed July 5, 2018, has a PE of 0.47 the highest for this date and will be paid at the full allowable of $36.16. 58.31/35.9996 x $36.16 = $58.57
- Procedure code G0283, billed July 5, 2018, has a PE of 0.23 not the highest for this date and will be paid at the reduced allowable of 11.14. 58.31/35.9996 x $11.14 = $18.04
- Procedure code 97110, billed July 7, 2018, for 4 units has a PE of 0.4 not the highest for this date and will be paid at the reduced rate of $24.48. 58.31/35.9996 x $24.48 x 4 = $158.60
- Procedure code 97140, billed July 7, 2018, for 2 units has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of $22.50. 58.31/35.9996 x $22.50 x 2 = $72.89
- Procedure code 97112, billed July 7, 2018, has a PE of 0.47 the highest for this date and will be paid at the full allowable of $36.16. 58.31/35.9996 x $36.16 = $58.57
- Procedure code G0283, billed July 7, 2018, has a PE of 0.23 not the highest for this date and will be paid at the reduced allowable of 11.14. 58.31/35.9996 x $11.14 = $18.04

4. The total allowable reimbursement for the services in dispute is $1,540.50. The carrier's previous payment of $977.80 leaves an amount due to the requestor of $562.70. 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 $562.70.

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 $562.70, 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	September 19, 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.