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
M4-18-5321-01

Carrier's Austin Representative
Box Number 21

MFDR Date Received
August 30, 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: $361.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The preauthorization was limited per the Official Disability Guidelines to 4 modalities per date of service. The bills submitted exceeded the preauthorization approval."

Response Submitted by: Thornton Biechlin Reynolds & Guerra

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 9 – 11, 2018	97110 -GP, 97140 -GP	$361.02	$0.00

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 §134.600 sets out the guidelines for prior authorization.
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/the multiple procedure rules
   - 168 – Billed charge is greater than maximum unit value of daily maximum allowance for physical therapy/physical medicine services.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking $361.02 for physical therapy services rendered from July 9 – 11, 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 168 – "Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services. The respondent states in their position statement, "The bills submitted exceeded the preauthorization approval."

   28 TAC §134.600 (p) states in pertinent part,

   Non-emergency health care requiring preauthorization includes:

   (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 "Preauthorization determination letter" dated June 14, 2018 states;

   - Requested Services: 97110, 97112, and 97140. Dates of service June 14, 2018 to July 27, 2018. Guideline ODG.
   - Generally there should be no more than 4 modalities/procedural units in total per visit…
   - limiting the total length of each PT visit to 45-60 minutes unless additional circumstances exist requiring extended length of treatment.

   Review of the submitted medical bill found units submitted for dates of service July 9 and 11, 2018 was 8 for a total of 120 minutes. Based on this review, the respondent's position is supported as the total billed units and minutes billed does exceed those of the authorization. No additional payment is recommended as insufficient evidence was found to support additional circumstances existed that required extended length of treatment.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		October 3, 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, 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.