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
Blue Lagune Therapy Inc

Respondent Name
Travelers Property Casualty Company of America

MFDR Tracking Number
M4-19-0313-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
September 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review the attached claim and have procedure 3 units of procedure 97113 be reconsidered for payment as the services were performed base on medical necessity with prior authorization and without any limitation set forth by the workers comp carrier."

Amount in Dispute: $330.00

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
June 4, 2018	97113	$330.00	$126.99

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

- P12 – Workers compensation jurisdictional fee schedule adjustment

Issues

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

Findings

1. The requestor is seeking additional reimbursement in the amount of $330.00 for physical therapy services rendered on June 4, 2018. The carrier denied/reduced the services in dispute as, 119 – "Benefit maximum for this time period or occurrence has been reached" and 163 – "The charge for this procedure exceeds the unit value and/or the multiple procedure rules."

   28 Texas Administrative Code 134.203 (a) (5) and (b) (1) states in pertinent part,

   > "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.

   Review of the Medicare Claims Processing Manual, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html , Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services 20.2 – D, which states in pertinent part,

   > *Reporting of Service Units With HCPCS, D. 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.*

   However, the code in dispute 97113 is not listed on this chart. Therefore, the carrier's denial is not supported.

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

   28 Texas Administrative Code §134.203 (b) (1) states in pertinent part,

   > 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;

   The Centers for Medicare and Medicaid Claims Processing Manual, Chapter 5, states in applicable section 10.7,

   > *Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology.*
   >
   > *Full payment is made for the unit or procedure with the highest PE payment.*
   >
   > *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.*

   The calculation of the maximum allowable reimbursement based applicable Medicare reduction and DWC fee guideline is shown in the next paragraph.

2. The DWC fee guideline is found at 28 Texas Administrative Code 134.203 (c) which 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 Medicare Multiple Procedure Payment Reduction file is found at:

   https://www.cms.gov/Medicare/Billing/TherapyServices/index.html

   To ensure appropriate application of the MPPR all services billed on the date of service in dispute is calculated as follows:

   - Procedure code 97113 with billed date of June 4, 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.
   - Procedure code 97530 with billed date of June 4, 2018 has a PE of 0.69 the highest for this date and will be paid at the full allowable of $39.71. 58.31/35.9996 x $39.71 = $64.32.

3. The allowable for the services provided is $337.89. The carrier paid $210.90. A balance of $126.99 is due to the health care provider.

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 $126.99.

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 $126.99, 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 17, 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.