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
TEXAS HEALTH KAUFMAN

Respondent Name
OLD REPUBLIC INSURANCE COMPANY

MFDR Tracking Number
M4-19-0338-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
September 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please reconsider, modifier 59 has been added to CPT 97164 to override the conflicting codes."

Amount in Dispute: $872.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per NCCI code 97012 has a conflict with code 97140. They are not both reimbursable absent the appropriate modifier. That modifier was not on the provider's UB-04."

Response Submitted by: Gallagher Bassett and Flahive, Odgen & Latson, Attorneys at Law, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 5, 2018 to March 30, 2018	Outpatient Physical Therapy: CPT 97140	$872.56	$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 §134.403 sets out the hospital facility fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - P300 – The amount paid reflects a fee schedule reduction.
   - Z710 - The charge for this procedure exceeds the fee schedule allowance.
   - Z652 - Recommendation of payment has been based on a procedure code which best describes the services rendered.
   - W3 – Request for reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is the recommended payment for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards physical therapy services performed in an outpatient facility. Such services are not paid under Medicare's Outpatient Prospective Payment System but using Medicare's Physician Fee Schedule. Per DWC's *Hospital Facility Fee Guideline*, Rule §134.403(h), if Medicare reimburses using other fee schedules, DWC guidelines applicable to the code on the date provided are used for payment. DWC *Medical Fee Guideline for Professional Services*, Rule §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.

   Per Medicare's correct coding initiative (CCI) payment policy, procedure code 97140, billed for March 5, March 6, March 9, March 20, March 21, March 23, March 26, March 28, and March 30, 2018, may not be reported with code 97012, performed on each of the same dates. Reimbursement for this procedure is included in the payment for code 97012. A modifier may be used to distinguish separate payment (if supported by the medical records); however, the provider did not bill code 97140 with any appropriate modifiers to distinguish separate services. Accordingly, additional payment cannot be recommended.

   The following items were billed without code 97012 performed on the same date and are not subject to CCI edits. Reimbursement is calculated as follows:

   - Procedure code 97140, March 12, 2018, has a Work RVU of 0.43 multiplied by the Work GPCI of 1 is 0.43. The practice expense RVU of 0.35 multiplied by the PE GPCI of 0.938 is 0.3283. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.796 is 0.00796. The sum is 0.76626 multiplied by the DWC conversion factor of $58.31 for a MAR of $44.68. Per Medicare payment policy regarding multiple therapy payment reduction, for each extra therapy unit beyond the first unit of the code with the highest practice expense (PE) on each date, payment is reduced by 50% of the practice expense. This code has the highest PE for this date. The first unit of this service is paid at $44.68. The PE reduced rate is $35.11 at 3 units is $105.33. The total for 4 units is $150.01.
   - Procedure code 97140, March 15, 2018, has a Work RVU of 0.43 multiplied by the Work GPCI of 1 is 0.43. The practice expense RVU of 0.35 multiplied by the PE GPCI of 0.938 is 0.3283. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.796 is 0.00796. The sum is 0.76626 multiplied by the DWC conversion factor of $58.31 for a MAR of $44.68. For each extra therapy unit beyond the first unit of the code with the highest practice expense (PE) on each date, payment is reduced by 50% of the practice expense. The PE for this code is not the highest for this date. The PE reduced rate is $35.11, at only 1 unit billed is $35.11.
   - Procedure code 97140, March 16, 2018, has a Work RVU of 0.43 multiplied by the Work GPCI of 1 is 0.43. The practice expense RVU of 0.35 multiplied by the PE GPCI of 0.938 is 0.3283. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.796 is 0.00796. The sum is 0.76626 multiplied by the DWC conversion factor of $58.31 for a MAR of $44.68. Per Medicare payment policy regarding multiple therapy payment reduction, for each extra therapy unit beyond the first unit of the code with the highest practice expense (PE) on each date, payment is reduced by 50% of the practice expense. This code has the highest PE for this date. The first unit of this service is paid at $44.68. The PE reduced rate is $35.11 at 3 units is $105.33. The total for 4 units is $150.01.

2. The total MAR (maximum allowable reimbursement) for the disputed services is $335.13. The insurance carrier paid $402.12, leaving an amount due to the requestor of $0.00. No additional payment 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 evidence presented by the requestor and respondent available 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 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

	Grayson Richardson	November 2, 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 division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Include a copy of this *Medical Fee Dispute Resolution Findings and Decision*** together with any other information required by 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.