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
Elite Healthcare Garland

Respondent Name
Hartford Fire Insurance Co

MFDR Tracking Number
M4-19-0674-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 8, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The preauthorization, that does not specify unit restrictions, is attached. RULE 134.600 (n) "The carrier shall not condition an approval or change any elements of the requests as listed in subsection (f), unless the condition or change is mutually agreed to by the health care provider and carrier and the agreement is documented."

Amount in Dispute: $139.74

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services were processed in accordance with Texas Guidelines, Rule 134.200."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 16, 2018	97110, 97112	$139.74	$60.11

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

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

Issues

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

Findings

1. The requestor is seeking additional reimbursement in the amount of $139.74 for physical therapy services rendered on July 16, 2018. The carrier denied/reduced the services in dispute as, 119 – "Benefit maximum for this time period or occurrence has been reached" and 168 – "Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services."

   28 TAC 134.203(b) 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;

   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 codes in dispute 97110, and 97112 are not listed on this chart.

   Therefore, the carrier's denial is not supported. As no other denials or defenses were raised either on the explanation of benefits or by the carrier, the services in dispute will be reviewed per applicable fee guideline shown below.

2. 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.
   >
   > (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;

   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 is shown in the next paragraph.

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 Medicare Multiple Procedure Payment Reduction file is found at:

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

   The MAR calculation is as follows:

   - Procedure code 97110, with a billed date of July 16, 2018. This code has a practice expense of 0.4 the highest for this date. The first unit will be paid at the full allowable of $30.28. 58.31/35.9996 x $30.28 = $40.95. The second, third and fourth units will be paid at the reduced allowable of $23.53. 58.31/35.9996 x $23.53 x 3 = $114.34. $40.95 + $114.34 = $155.29
   - Procedure code 97112, with a billed date of July 16, 2018. This code has a practice expense of 0.35 not the highest for this date and will be paid at the reduced allowable of $26.51. 58.31/35.9996 x $26.51 x 2 = $85.88

4. The total allowable reimbursement for the services in dispute is $241.17. The carrier paid $181.06. The remaining balance of $60.11 is due to the requestor.

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 $60.11.

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 $60.11, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order

Authorized Signature

		December 12, 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.