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
Pain Rehabilitation Solution

Respondent Name
Property & Casualty Ins Co of the Hartford

MFDR Tracking Number
M4-19-1101-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
April 18, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attached hicfa's, preauthorization letter, medical notes, med risk letter Please process our bills accordingly..."

Amount in Dispute: $22,465.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Bills from 9/27/17 thru 10/9/17 will not be reviewed as these are past the timely filing deadline per Rule 133.307 B1. We have no record of the bills from 1/4/18 to 3/12/18 and 8/1/18 in our payment system; but as the provider has submitted documentation to indicate timely billing, we have now entered the bill and issued payment. DOS 5/9/18 has been reviewed and denied correctly as 99354 is an add-on code and no primary CPT was billed for the DOS."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 27 through October 9, 2017 January 4 through August 1, 2018	Professional medical services	$22,465.00	$2,193.81

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. 28 Texas §134.204 sets out the reimbursement guidelines of workers compensation specific services.
4. 28 Texas §134.600 sets out the requirements for prior authorization.
5. 28 Texas §133.240 sets out the requirements of medical payments and denials
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules
   - 5917 – Pre-authorization was required, but not requested for this service per DWC Rule 134.600
   - 5876 – According to the Texas Division of Workers Compensation's rules effective May 1, 2007, all medical treatment provided to workers compensation patients in the State of Texas must follow the Official Disability Guidelines (ODG). The services provided are outside the ODG guidelines and no pre authorization was requested
   - 906 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient code editor).
   - 876 – Fee schedule amount is equal to the charge
   - 4961 – The hourly rate has been reduced to fifteen minute increments due to the modifier billed
   - 309 – The charge for this procedure exceeds the fee schedule allowance

Issues

1. Are the services from 2017 submitted timely to MFDR?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is Medicare payment policy?
4. What rule(s) is applicable to reimbursement guidelines?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states, ""Bills from 9/27/17 thru 10/9/17 will not be reviewed as these are past the timely filing deadline per Rule 133.307 B1." Review of the submitted DWC060 finds codes 97110, 97140 and 97530 were listed in dispute for dates of service September 27, 2017 through October 9, 2017. 28 TAC §133.307 (c) (1) (A) states in pertinent part, "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR." The request for MFDR was received on October 29, 2018. This date is greater than one year after the date of service. The insurance carrier's position is supported, these dates of service will not be considered in this review.

2. The remaining disputed dates of service from January 4, 2018 to August 1, 2018 will be reviewed per applicable Division rules and fee guidelines. The carrier denied/reduced the services in dispute as, 163 – "The charge for this procedure exceeds the unit value and/or the multiple procedure rules."

   28 TAC §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

   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 97140 are not listed on this chart.

   The carrier's denial is not supported. The remaining denials are addressed below.

3. 28 TAC §134.203 (a) (5) 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.

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 after the application of the MPPR is shown in the next paragraph.

4. 28 TAC §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 97164, billed January 4, 2018 was the only service provided on this date. 58.31/35.9996 x $58.79 = $95.22. The carrier paid $60.00. The requestor is seeking $60.00. No additional payment is recommended.
- Procedure code 97110, billed January 10, 2018 has a PE of 0.4 the highest for this date and will be paid at the full allowable of $31.77. 58.31/35.9996 x $31.77 = $51.46 the maximum allowable reimbursement. The requestor is seeking $75.00. No additional payment is recommended.
- Procedure code 97140, billed January 10, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced allowable of $22.50. 58.31/35.9996 x $22.50 = $36.44 or the MAR. The carrier paid $36.44. No additional payment is recommended.
- Procedure code 97035, billed January 10, 2018 was denied as 5917 – "Pre-authorization was required, but not requested for this service per DWC Rule 134.600." 28 TAC 134.600 (p) (5) (A) (i) and (ii) states in pertinent part, "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;" Insufficient evidence was found to support this service was authorized by the insurance carrier. The carrier's denial is supported, no additional payment is recommended.

- Procedure code 97110, billed January 18, 2018 for three units has a PE of 0.4 the highest for this date. The first unit will be paid at the full allowable of $31.77. The second and third units will be paid at the reduced rate of $24.48. 58.31/35.9996 x $31.77 = $51.46. 58.31/35.9996 x $24.48 x 2 = $79.30. $51.46 + $79.30 = $130.76. The carrier paid $75.00. The requestor is seeking $75.00. No additional payment is recommended.
- Procedure code 97140, billed January 18, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced allowable of $22.50. 58.31/35.9996 x $22.50 = $36.44 or the MAR. The carrier paid $36.44. No additional payment is recommended.
- Procedure code 97035, billed January 18, 2018 was denied for lack of authorization. As detailed above, the carrier's denial is supported, no additional payment is recommended.
- Procedure code 97110, billed January 19, 2018 for three units has a PE of 0.4 the highest for this date. The first unit will be paid at the full allowable of $31.77. The second and third units will be paid at the reduced rate of $24.48. 58.31/35.9996 x $31.77 = $51.46. 58.31/35.9996 x $24.48 x 2 = $79.30. $51.46 + $79.30 = $130.76. The carrier paid $75.00. The requestor is seeking $75.00. No additional payment is recommended.
- Procedure code 97140, billed January 19, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced allowable of $22.50. 58.31/35.9996 x $22.50 = $36.44 or the MAR. The carrier paid $36.44. No additional payment is recommended.
- Procedure code 97035, billed January 19, 2018 was denied for lack of authorization. As detailed above, the carrier's denial is supported, no additional payment is recommended.
- Procedure code 97110, billed January 24, 2018 for three units has a PE of 0.4 the highest for this date. The first unit will be paid at the full allowable of $31.77. The second and third units will be paid at the reduced rate of $24.48. 58.31/35.9996 x $31.77 = $51.46. 58.31/35.9996 x $24.48 x 2 = $79.30. $51.46 + $79.30 = $130.76. The carrier paid $75.00. The requestor is seeking $75.00. No additional payment is recommended.
- Procedure code 97110, billed February 7, 2018 for three units has a PE of 0.4 the highest for this date. The first unit will be paid at the full allowable of $31.77. The second and third units will be paid at the reduced rate of $24.48. 58.31/35.9996 x $31.77 = $51.46. 58.31/35.9996 x $24.48 x 2 = $79.30. $51.46 + $79.30 = $130.76. The carrier paid $75.00. The requestor is seeking $75.00. No additional payment is recommended.
- Procedure code 97140, billed February 7, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced allowable of $22.50. 58.31/35.9996 x $22.50 = $36.44 or the MAR. The carrier paid $36.44. No additional payment is recommended.
- Procedure code 97035, billed February 7, 2018 was denied for lack of authorization. As detailed above, the carrier's denial is supported, no additional payment is recommended.
- Procedure code 97110, billed February 9, 2018 for three units has a PE of 0.4 the highest for this date. The first unit will be paid at the full allowable of $31.77. The second and third units will be paid at the reduced rate of $24.48. 58.31/35.9996 x $31.77 = $51.46. 58.31/35.9996 x $24.48 x 2 = $79.30. $51.46 + $79.30 = $130.76. The carrier paid $75.00. The requestor is seeking $75.00. No additional payment is recommended.
- Procedure code 97140, billed February 9, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced allowable of $22.50. 58.31/35.9996 x $22.50 = $36.44 or the MAR. The carrier paid $36.44. No additional payment is recommended.
- Procedure code 97035, billed February 9, 2018 was denied for lack of authorization. As detailed above, the carrier's denial is supported, no additional payment is recommended.
- Procedure code 97110, billed February 14, 2018 for three units has a PE of 0.4 the highest for this date. The first unit will be paid at the full allowable of $31.77. The second and third units will be paid at the

reduced rate of $24.48. 58.31/35.9996 x $31.77 = $51.46. 58.31/35.9996 x $24.48 x 2 = $79.30. $51.46 + $79.30 = $130.76. The carrier paid $75.00. The requestor is seeking $75.00. No additional payment is recommended.

- Procedure code 97140, billed February 14, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced allowable of $22.50. 58.31/35.9996 x $22.50 = $36.44 or the MAR. The carrier paid $36.44. No additional payment is recommended.
- Procedure code 97035, billed February 14, 2018 was denied for lack of authorization. As detailed above, the carrier's denial is supported, no additional payment is recommended.
- Procedure code 97110, billed February 16, 2018 for three units has a PE of 0.4 the highest for this date. The first unit will be paid at the full allowable of $31.77. The second and third units will be paid at the reduced rate of $24.48. 58.31/35.9996 x $31.77 = $51.46. 58.31/35.9996 x $24.48 x 2 = $79.30. $51.46 + $79.30 = $130.76. The carrier paid $75.00. The requestor is seeking $75.00. No additional payment is recommended.
- Procedure code 97140, billed February 16, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced allowable of $22.50. 58.31/35.9996 x $22.50 = $36.44 or the MAR. The carrier paid $36.44. No additional payment is recommended.
- Procedure code 97035, billed February 16, 2018 was denied for lack of authorization. As detailed above, the carrier's denial is supported, no additional payment is recommended.
- Procedure code 97110, billed February 23, 2018 for three units has a PE of 0.4 the highest for this date. The first unit will be paid at the full allowable of $31.77. The second and third units will be paid at the reduced rate of $24.48. 58.31/35.9996 x $31.77 = $51.46. 58.31/35.9996 x $24.48 x 2 = $79.30. $51.46 + $79.30 = $130.76. The carrier paid $75.00. The remaining balance of $55.76 is due to the requestor.
- Procedure code 97140, billed February 23, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced allowable of $22.50. 58.31/35.9996 x $22.50 = $36.44 or the MAR. The carrier paid $36.44. No additional payment is recommended.
- Procedure code 97035, billed February 23, 2018 was denied for lack of authorization. As detailed above, the carrier's denial is supported, no additional payment is recommended.
- Procedure code 97110, billed March 9, 2018 for three units has a PE of 0.4 the highest for this date. The first unit will be paid at the full allowable of $31.77. The second and third units will be paid at the reduced rate of $24.48. 58.31/35.9996 x $31.77 = $51.46. 58.31/35.9996 x $24.48 x 2 = $79.30. $51.46 + $79.30 = $130.76. The provider billed $75.00. The carrier paid $75.00. No additional payment is recommended.
- Procedure code 97140, billed March 9, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced allowable of $22.50. 58.31/35.9996 x $22.50 = $36.44 or the MAR. The carrier paid $36.44. No additional payment is recommended.
- Procedure code 97035, billed March 9, 2018 was denied for lack of authorization. As detailed above, the carrier's denial is supported, no additional payment is recommended.
- Procedure code 97110, billed March 12, 2018 has a PE of 0.4 the highest for this date and will be paid at the full allowable of $31.77. 58.31/35.9996 x $31.77 = $51.46. The carrier paid $51.46. No additional payment is recommended.
- Procedure code 97140, billed March 12, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced allowable of $22.50. 58.31/35.9996 x $22.50 = $36.44 or the MAR. The carrier paid $36.44. No additional payment is recommended.
- Procedure code 99354 – "Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or

other outpatient Evaluation and Management or psychotherapy service)" The insurance carrier states, "DOS 5/9/18 has been reviewed and denied correctly as 99354 is an add-on code and no primary CPT was billed for the DOS." Based on the information provided, the carrier's position is supported. No additional payment is recommended.

28 TAC 134.203 (c) (1) determines the maximum allowable reimbursement for the following services.

- Procedure code 90791 billed August 1, 2018 has an allowable of $138.64. 58/31.35.9996 X $138.64 = $224.56. The carrier paid $224.56. No additional payment is recommended.
- Procedure code 96101 billed August 1, 2018 was denied as "The services provided are outside the ODG Guidelines and no pre authorization was requested." 28 TAC 133.240 (q) states in pertinent part,

> When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title (relating to Notice of Determinations Made in Utilization Review). Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination), including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

Review of the submitted documentation found insufficient evidence to support the insurance carrier provided the health care provider an opportunity to discuss the billed health care with a health care professional. The insurance carrier's denial is not supported.

The allowed amount is $85.23. 58.31/35.9996 x $85.23 = $138.05. This amount is recommended.

- Procedure code 90885 has a CCI conflict with code 90791. Based on 28 TAC 134.203 (b) (1) which states, "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" no additional payment is recommended.

28 TAC 134.204 (h) (5) (A) determines the allowable for the remaining services in dispute and states in pertinent part,

> The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.
>
> (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill.
>
> (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

Review of the submitted medical bill finds the following;

- Procedure code 97799 CP billed July 9, 2018 for 8 units x $125.00 = $1,000.00. The carrier paid $800. The remaining balance of $200 is due to the requestor.
- Procedure code 97799 CP billed July 11, 2018 for 8 units x $125.00 = $1,000.00. The carrier paid $800. The remaining balance of $200 is due to the requestor.
- Procedure code 97799 CP billed July 12, 2018 for 8 units x $125.00 = $1,000.00. The carrier paid $800. The remaining balance of $200 is due to the requestor.
- Procedure code 97799 CP billed July 13, 2018 for 8 units x $125.00 = $1,000.00. The carrier paid $800. The remaining balance of $200 is due to the requestor.

- Procedure code 97799 CP billed July 16, 2018 for 8 units x $125.00 = $1,000.00. The carrier paid $800. The remaining balance of $200 is due to the requestor.
- Procedure code 97799 CP billed July 18, 2018 for 8 units x $125.00 = $1,000.00. The carrier paid $800. The remaining balance of $200 is due to the requestor.
- Procedure code 97799 CP billed July 19, 2018 for 8 units x $125.00 = $1,000.00. The carrier paid $800. The remaining balance of $200 is due to the requestor.
- Procedure code 97799 CP billed July 20, 2018 for 8 units x $125.00 = $1,000.00. The carrier paid $800. The remaining balance of $200 is due to the requestor.
- Procedure code 97799 CP billed July 25, 2018 for 8 units x $125.00 = $1,000.00. The carrier paid $800. The remaining balance of $200 is due to the requestor.
- Procedure code 97799 CP billed July 27, 2018 for 8 units x $125.00 = $1,000.00. The carrier paid $800. The remaining balance of $200 is due to the requestor.

5. The calculation above of the Division fee guidelines for the dates of service in dispute have found a payment of $2,193.81 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 $2,193.81.

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 $2,193.81 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	January 24, 2019 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.