TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Patient Care Injury Clinic

Respondent Name
City of Houston

MFDR Tracking Number
M4-19-2263-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
December 19, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier did not authorize 4 units. We requested three modalities and the carrier paid the lesser modality with a mx of 4 units."

Amount in Dispute: $541.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation a payment is being issued in the amount of $253.07 including interest."

Response Submitted by: Injury Management Organization

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15, 2018 August 17, 2018 September 12, 2018	97110 –GP, 97140 –GP 97110 -GP, 97140 -GP 97110 – GP, 97140 -GP	$541.53	$123.39

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 Administrative Code §134.600 sets out specifics of prior authorization of medical services.
4. 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

- 168 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services
- 193 – Original payment decision is being maintained
- 296 – Service exceeds maximum reimbursement guidelines

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 $541.53 for physical therapy services rendered from August 15, 2018 through September 12, 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 134.600 (c) (1) states in pertinent part,

   > The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:
   >
   > (1) listed in subsection (p) or (q) of this section only when the following situations occur:
   >
   > (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

   Review of the "Preauthorization Determination Letter" dated August 2, 2018 indicates the following:

CPT	Status	Authorization	Dates of Service
97110	Preauthorized	115683	08/02/18 to 09/21/18
97112	Preauthorized	115683	08/02/18 to 09/21/18
97140	Preauthorized	115683	08/02/18 to 09/21/18

   Insufficient evidence was found to support the preauthorization letter limited the number of units. DWC finds the carriers reduction is not supported. The services in dispute will be reviewed per applicable rules and division fee guidelines.

2. 28 TAC 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.*

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 based on the Medicare payment policy and division fee guidelines is as follows:

- Procedure code 97110, billed August 15, 2018, four 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. 58.31/35.9996 x $31.77 = $51.46. The second, third and fourth units will be paid at the reduced rate of $24.48. 58.31/35.9996 x $24.48 x 3 = $118.95. $51.46 + $118.95 = $170.41.
- Procedure code 97140, billed August 15, 2018, two units has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of $22.50. 58.31/35.9996 x $22.50 x 2 = $72.89
- Procedure code 97110, billed August 17, 2018, four 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. 58.31/35.9996 x $31.77 = $51.46. The second, third and fourth units will be paid at the reduced rate of $24.48. 58.31/35.9996 x $24.48 x 3 = $118.95. $51.46 + $118.95 = $170.41.
- Procedure code 97140, billed August 17, 2018, two units has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of $22.50. 58.31/35.9996 x $22.50 x 2 = $72.89
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- Procedure code 97140, billed September 12, 2018, two units has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of $22.50. 58.31/35.9996 x $22.50 x 2 = $72.89

3. The total allowable reimbursement for the services in dispute is $729.90. The carrier made a total payment of $606.51 the balance of $123.39 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 $123.39.

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 $123.39, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		February 7, 2019
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.