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 South Dallas

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-19-2627-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
January 14, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Liberty mutual approved 10 physical therapy sessions with CPT codes 97110, 97112, 97140 without specifying a daily maximum allowance, therefore all eight units should be paid 100% in full,"

Amount in Dispute: $232.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual is not questioning the medical necessity of the services rendered. The reductions that are applied are to the CMS limitations on the number of physical therapy units allowed per day."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 31, 2018	97110, 97112, 97140	$232.78	$148.82

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:
   - 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules

- 183 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services

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 $232.78 for physical therapy services rendered on July 31, 2018. The carrier reduced the services in dispute as "daily maximum allowance being exceeded." The respondent states in their response, "The reductions that are applied are related to the CMS limitations on the number of physical therapy units allowed per day."

   Review of the submitted documentation found insufficient evidence to support the "CMS limitations" cited by the respondent. Further review found a letter dated June 28, 2018 that prior authorized physical therapy for the left shoulder with CPT codes- 97110, 97140, and 97112 for dates of service 6/27/18 – 8/29/18.

   28 TAC 134.600 (c) (1) (B) and (n) state in pertinent parts,

   > 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;
   >
   > (n) The insurance carrier shall not condition an approval or change any elements of the request as listed in subsection (f) of this section, unless the condition or change is mutually agreed to by the health care provider and insurance carrier and is documented.

   The physical therapy services in dispute were prior authorized without limit of units on the dates of service. Insufficient evidence was found that the insurance carrier and health care provider mutually agreed to any changes. The carrier's reduction in number of units is not supported. The denial based on daily maximum will not be considered in this review. The allowable reduction based on "multiple procedure rules" is discussed below.

2. 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 is supported and used below in the calculation of the maximum allowed reimbursement.

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, billed July 31, 2018 for four units has a PE of 0.4 the highest for this date of service. The first unit will be paid at the full allowable of $31.55. The second, third and fourth units will be paid at the reduced rate of $24.25. 58.31/35.9996 x $31.55 = $51.10. 58.31/35.9996 x $24.23 x 3 = $117.84. $51.10 + $117.84 = $168.94
   - Procedure code 97112, billed July 31, 2018 for 2 units has a PE of 0.47 not the highest for this date and will be paid at the reduced rate of $27.35. 58.31/35.9996 x $27.35 x 2 = $88.60
   - Procedure code 97140, billed July 31, 2018 for 2 units has a PE of 0.35 not the highest for this date and will be paid at the reduced rate $22.33. 58.31/35.9996 x $22.33 x 2 = $72.34

4. The total allowable reimbursement for the services in dispute is $329.88. The carrier paid $181.06. The remaining balance of $148.82 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 $148.82.

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 $148.82, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		March 20, 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.