



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

ELITE HEALTHCARE SOUTH DALLAS

Respondent Name

LM INSURANCE CORP

MFDR Tracking Number

M4-19-2629-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

January 14, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Liberty mutual approved 6 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: \$698.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The reductions that are applied are related to the CMS limitations on the number of physical therapy units allowed per day."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Dispute Amount, Amount Due. Row 1: July 30, 2018, Physical Medical Services, \$698.34, \$452.67

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 fee guideline for professional medical services.
3. Texas Labor Code §408.021 entitles an injured employee to all required health care as and when needed.
4. 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 MULTIPLE PROCEDURE RULES
• 876 – FEE SCHEDULE AMOUNT IS EQUAL TO THE CHARGE.
• 168 – BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES
• B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
• W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

1. Were the disputed physical medicine services subject to a maximum unit value or daily allowance?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
 - 168 – BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES

The requestor states that “Liberty mutual approved 6 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 ...”

The respondent asserts that “The reductions that are applied are related to the CMS limitations on the number of physical therapy units allowed per day.”

In support of their position, the respondent cites Rule §134.203(b)(1), which 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; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

Rule §134.203(a)(5) defines Medicare payment policies to 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.

While the division has adopted Medicare *payment* policies in administering the medical fee guidelines, the division has not adopted Medicare *benefit* policies. Texas Labor Code §408.021 specifies an injured employee’s entitlement to medical benefits, including “all health care reasonably required by the nature of the injury *as and when needed*.” The division has further adopted treatment guidelines and procedures for preauthorization of services and dispute of medical necessity that take precedence over any conflicting Medicare provisions.

The insurance carrier did not present any information to support its denial reasons based on “maximum unit value” or “daily maximum allowance” for physical medicine services. Review of the submitted pre-authorization approval letter finds the disputed services were preauthorized. The letter did not contain any limitations with respect to units performed or daily maximum time limits.

The insurance carrier’s denial reasons are not supported. The disputed services will therefore be reviewed for reimbursement in accordance with division rules and fee guidelines.

2. This dispute regards medical services with reimbursement subject to the *Medical Fee Guideline for Professional Services*, 28 Texas Administrative Code §134.203, requiring the maximum allowable reimbursement (MAR) be determined by Medicare payment policies modified by DWC rules. The MAR is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the DWC annual conversion factor.

When more than one unit is billed of therapy services designated by multiple-procedure payment indicator ‘5’, Medicare policy requires the first unit of therapy with the highest practice expense for that day be paid in full. Payment is reduced by 50% of the practice expense (PE) for each extra therapy unit provided on that date.

Reimbursement is calculated as follows:

- Procedure code 97110 (July 26, July 27, and July 30, 2018) has a Work RVU of 0.45 multiplied by the Work GPCI of 1.012 is 0.4554. The practice expense RVU of 0.4 multiplied by the PE GPCI of 1.014 is 0.4056. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.768 is 0.01536. The sum is 0.87636 multiplied by the DWC conversion factor of \$58.31 for a MAR of \$51.10. For each extra therapy unit after the first unit of the code with the highest PE, payment is reduced by 50% of the practice expense. The PE for this code is not the highest. The PE reduced rate is \$39.28 at 4 units is \$157.12. This amount multiplied by 3 sessions is \$471.36.
- Procedure code 97112 (July 26, July 27, and July 30, 2018) has a Work RVU of 0.5 multiplied by the Work GPCI of 1.012 is 0.506. The practice expense RVU of 0.47 multiplied by the PE GPCI of 1.014 is 0.47658. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.768 is 0.01536. The sum is 0.99794 multiplied by the DWC conversion factor of \$58.31 for a MAR of \$58.19. For each extra therapy unit after the first unit of the code with the highest practice expense (PE) for each date, payment is reduced by 50% of the PE. This code has the highest PE for these dates. The first unit is paid at \$58.19. The second unit is paid at the PE reduced rate of \$44.30. The total is \$102.49. This amount multiplied by 3 sessions is \$307.47.
- Procedure code 97140 (July 26, July 27, and July 30, 2018) has a Work RVU of 0.43 multiplied by the Work GPCI of 1.012 is 0.43516. The practice expense RVU of 0.35 multiplied by the PE GPCI of 1.014 is 0.3549. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.768 is 0.00768. The sum is 0.79774 multiplied by the DWC conversion factor of \$58.31 for a MAR of \$46.52. For each extra therapy unit after the first unit of the code with the highest PE, payment is reduced by 50% of the practice expense. The PE for this code is not the highest. The PE reduced rate is \$36.17 at 2 units is \$72.34. This amount multiplied by 3 sessions is \$217.02.

The total allowable reimbursement for the disputed services is \$995.85. The insurance carrier paid \$543.18. The amount due is \$452.67. This amount is recommended.

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 \$452.67.

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 \$452.67, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	<u>Grayson Richardson</u>	<u>March 29, 2019</u>
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 DWCO45M) in accordance with the form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.