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
PATIENT CARE INJURY CLINIC PA

Respondent Name
ACCIDENT FUND NATIONAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-2769-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
January 18, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We feel that our facility should be paid according to the workers compensation fee schedule guidelines."

Amount in Dispute: $93.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the bill at issue was correctly audited..."

Response Submitted by: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 12, 2018	Physical Therapy - 97140	$93.58	$72.90

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 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:
   - 119 – BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
   - 168 – BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 1014 - THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.

Issues

1. Are the services subject to a benefit maximum, maximum unit value, or daily maximum allowance?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied payment for disputed services with claim adjustment reason code:
   - 119 – BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
   - 168 – BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES

   Texas Labor Code §408.021(a) guarantees that "An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed."

   The insurance carrier did not present any information to support that the injured employee's benefits are subject to a maximum, or that any maximum was exceeded. Procedure code 97140 was preauthorized; the approval letter does not specify any maximum unit value or daily maximum allowance. These denial reasons are not supported. The 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 97140, November 12, 2018, has a Work RVU of 0.43 multiplied by the Work GPCI of 1.02 is 0.4386. The practice expense RVU of 0.35 multiplied by the PE GPCI of 1.012 is 0.3542. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.936 is 0.00936. The sum is 0.80216 multiplied by the DWC conversion factor of $58.31 for a MAR of $46.77. For each extra therapy unit after the first unit of the code with the highest PE for that date, payment is reduced by 50% of the practice expense. The PE for this code is not the highest. The PE reduced rate is $36.45 at 2 units is $72.90.

   The total allowable reimbursement for disputed procedure code 97140 is $72.90. The insurance carrier paid $0.00. The amount due to the requestor is $72.90. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

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 $72.90.

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 $72.90, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	February 1, 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.

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 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.