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

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-19-2811-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
January 22, 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: $1,079.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Attached is extension request for M4-19-2811-01."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 19, 2018 through August 13, 2018	Physical therapy services	$1,079.36	$602.36

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:
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
   - 309 – The charge for this procedure exceeds the fee schedule allowance
   - 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

- 5917 – Pre-authorization was required, but not request for this service per DWC rule 134.600
- 5882 – Pre-authorization was requested but denied for this service per DWC Rule 134.600

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 $1,079.36 for physical therapy services rendered from July 19, 2018 through August 13, 2018. 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" and as 168 – "Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services" and 5917 and 5882 regarding preauthorization.23

   Review of the submitted documentation found insufficient evidence to support the basis of the "daily maximum allowance." This denial will not be considered in this review. The denied of Code for G0283 for lack of authorization is supported. No additional payment is recommended. The multiple procedure rule reduction is discussed below.

2. 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;

   The Medicare payment policy regarding multiple procedure payment reduction is found in the Centers for Medicare and Medicaid Claims Processing Manual, Chapter 5, which 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 health care provider on each date of service in dispute billed form three or four units of CPT code 97110, two units of CPT code 97140, one unit of 97112 and one unit of G0283. Per the above Medicare payment policy, "full payment is made for the unit or procedure with the highest PE payment." For the disputed services CPT code 97112 has the highest PE payment for each date of service in dispute, so the unit of 97112 should be paid at the full amount. Reimbursement of the services other than the first unit of 97112 will have the multiple procedure payment reduction applied.

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 services in dispute were provided in Houston, Texas in July and August of 2018. The formula for reimbursement is the Division of Workers Compensation Conversion Factor for 2018 divided by the Medicare Conversion Factor for 2018 multiple by the Medicare Fee amount. The Medicare Multiple Procedure Payment Reduction file is found at:
https://www.cms.gov/Medicare/Billing/TherapyServices/index.html

For CPT codes 97110, 97140, 97112 and G0283 provided in Irving Texas in 2018 the Medicare fee amounts are shown below.

CODE	SHORT DESCRIPTOR	FEE AMOUNT	50% REDUCTION	PRACTICE EXPENSE RVUs
97110	Therapeutic exercises	$31.77	$24.48	0.4
97140	Manual therapy	$28.88	$22.50	0.35
97112	Neuromuscular reeducation	$36.16	$27.60	0.47
G0283	Elec stim other than wound	$15.33	$11.14	0.23

For each of the below dates of service the reimbursement for the 97112 is DWC Conversion Factor 58.31 divided by the Medicare Conversion Factor 35.9996 multiplied by $36.16 = $58.57

For each of the below dates of service the units of 97110 are reimbursable at DWC Conversion Factor 58.31 divided by the Medicare Conversion Factor 35.9996 multiplied by the reduced amount of $24.48 = $39.65

For each of the below dates of service units of 97140 are reimbursable at DWC Conversion Factor 58.31 divided by the Medicare Conversion Factor 35.9996 multiplied by the reduced amount of $22.50 = $36.44

For each of the below date of service units of G0283 are reimbursable at DWC Conversion Factor 58.31 divided by the Medicare Conversion Factor 35.9996 multiplied by the reduced amount of $11.14 = $18.04

The Maximum Allowable Reimbursement (MAR) for dates of service July 19, 2018 through August 13, 2018 is shown below

Date of service	Submitted Code	Units	MAR per unit	Total MAR	Carrier paid
July 19, 2018	97110	4	$39.65	$158.60	$118.95
July 19, 2018	97140	2	$36.44	$72.89	
July 19, 2018	97112	1	$58.57	$58.57	$58.57
July 19, 2018	G0283	1	Denied for lack of authorization	N/A	N/A
July 20, 2018	97110	4	$39.65	$158.60	$118.95
July 20, 2018	97140	2	$36.44	$72.89	
July 20, 2018	97112	1	$58.57	$58.57	$58.57

July 20, 2018	G0283	1	Denied for lack of authorization	N/A	N/A
July 24, 2018	97110	4	$39.65	$158.60	$118.95
July 24, 2018	97140	2	$36.44	$72.89	
July 24, 2018	97112	1	$58.57	$58.57	$58.57
July 24, 2018	G0283	1	Denied for lack of authorization	N/A	N/A
July 26, 2018	97110	4	$39.65	$158.60	$118.95
July 26, 2018	97140	2	$36.44	$72.89	
July 26, 2018	97112	1	$58.57	$58.57	$58.57
July 26, 2018	G0283	1	Denied for lack of authorization	N/A	N/A
August 10, 2018	97110	3	$39.65	$118.95	$39.65
August 10, 2018	97140	2	$36.44	$72.89	$72.88
August 10, 2018	97112	1	$58.57	$58.57	$58.57
August 10, 2018	G0283	1	Denied for lack of authorization	N/A	N/A
August 13, 2018	97110	3	$39.65	$118.95	$118.95
August 13, 2018	97140	1	$36.44	$72.89	
August 13, 2018	97112	1	$58.57	$58.57	$58.57
August 13, 2018	G0283	1	Denied for lack of authorization	N/A	N/A
			Total	$1,661.06	$1,058.70

4. The total allowable reimbursement for the services in dispute is $1,661.06. The carrier made a total payment of $1,058.70. The remaining balance of $602.36 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 $602.36.

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 $602.36, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		July 9, 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.