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
James Construction Group LLC

MFDR Tracking Number
M4-19-2946-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 28, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted our bills and proper clinical documentation in a timely fashion. We feel that our facility should be paid according to the workers compensation fee schedule guidelines."

Amount in Dispute: $423.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier reduced the bills in compliance with rule 134.203(b)(1) which requires the application of Medicare payment policies in connection with the number of physical therapy units allowed per day. Carrier maintains that it has paid all reasonable, necessary and related medical care as it related to these two dates of service."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 19 – 21, 2018	Physical Therapy	$423.76	$42.86

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 guidelines for prior authorization.
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.
- 5917 – Pre-authorization was required, but not requested for this service per DWC Rule 134.600
- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules

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 for physical therapy services rendered July 19 and 21, 2018. The carrier reduced the services in dispute as "unit value being exceeded" and "multiple procedure rules." The respondent states in their response, "application of Medicare payment policies in connection with the number of physical therapy units allowed per day."

   Review of the submitted documentation found insufficient evidence to support the "physical therapy units allowed per day" cited by the respondent. Further review of the utilization review letter dated June 26, 2018 states, "…6/26/2018… 12 visits over 4 weeks of physical therapy for the bilateral shoulders; to include 97110, 97140."

   > Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program.

   28 TAC 134.600 (c) (1) (B) 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

   The carrier's reduction in number of units is not supported as the preauthorization did not limit the number of units. The denial of codes 97112 and G0283 for lack of authorization is supported as these services were not authorized as required in Rule 134.600 (p)(5) which states in pertinent part,

   > Non-emergency health care requiring preauthorization includes:
   > physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS)

   The allowable reduction based on "multiple procedure rules" is discussed below.

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.*

The Medicare Multiple Procedure Payment Reduction file is found at:

https://www.cms.gov/Medicare/Billing/TherapyServices/index.html

The calculation of the maximum allowable reimbursement is shown in the next paragraph.

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 MAR calculation is done for all services provided to appropriated apply the MPPR reduction as follows:

- Procedure code 97110, billed July 19, 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. The second, third and fourth units will be paid at the reduced rate of $24. 58.31/35.9996 x $31.77 = $51.46. 58.31/35.9996 x $24.48 x 3 = $118.95. $51.46 + $118.95
- Procedure code 97140, billed July 19, 2018, for two units has a PE of 0.35. 58.31/35.9996 x $22.50 x 2 = $72.89
- Procedure code 97112, billed July 19, 2018 was denied for lack of pre-authorization. The carrier's denial is supported. No additional payment is recommended.
- Procedure code G0283, billed July 19, 2018 was denied for lack of pre-authorization. The carrier's denial is supported. No additional payment is recommended.
- Procedure code 97110, billed July 21, 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. The second, third and fourth units will be paid at the reduced rate of $24. 58.31/35.9996 x $31.77 = $51.46. 58.31/35.9996 x $24.48 x 3 = $118.95. $51.46 + $118.95
- Procedure code 97140, billed July 21, 2018, for two units has a PE of 0.35. 58.31/35.9996 x $22.50 x 2 = $72.89
- Procedure code 97112, billed July 21, 2018 was denied for lack of pre-authorization. The carrier's denial is supported. No additional payment is recommended.
- Procedure code G0283, billed July 21, 2018 was denied for lack of pre-authorization. The carrier's denial is supported. No additional payment is recommended.

4. The total allowable reimbursement for the services in dispute is $383.68. The carrier made a total payment of $340.82. The remaining balance of $42.86 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 $42.86.

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 $42.86, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		March 29, 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.