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
PATIENT CARE INJURY CLINIC PA

Respondent Name
SENTINEL INSURANCE COMPANY LTD

MFDR Tracking Number
M4-19-3002-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
January 31, 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: $347.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services in dispute were processed in accordance with Texas Workers' Compensation Rule 134.203."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 5, 2018 to November 21, 2018	Physical Therapy Services - 97110	$347.72	$76.06

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:
   - 119 – BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
   - 163 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE UNIT VALUE AND/OR MULTIPLE PROCEDURE RULES
   - 309 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 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.
   - 1115 - WE FIND THE ORIGINAL REVIEW TO BE ACCURATE AND ARE UNABLE TO RECOMMEND ANY ADDITIONAL ALLOWANCE

Issues

1. Are the services subject to a benefit maximum?
2. What is the recommended payment for the services?
3. 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

   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 the injured employee's benefits are subject to a maximum. Procedure code 97110 was preauthorized; the approval letter does not specify any maximum in regard to units or duration per visit. This denial reason is not supported. The services will therefore be reviewed for reimbursement in accordance with division rules and fee guidelines.

2. This dispute regards physical therapy services with payment 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.

   The division notes that only one code per visit (97110) for four visits is in dispute. However, because the determination of payment is dependent on the presence or absence of other codes on the bill, and because the carrier underpaid the disputed services but overpaid other lines on the same bills, the division will calculate the payments for all the services on each bill and deduct the carrier's total amount paid from the total recommended reimbursement to determine the total amount remaining due from the carrier.

   The division further notes that the billing codes and units billed were the same for all 4 visits in dispute.

   Reimbursement is calculated as follows:

   - Procedure code 97110, November 5, 2018, has a Work RVU of 0.45 multiplied by the Work GPCI of 1.02 is 0.459. The practice expense RVU of 0.4 multiplied by the PE GPCI of 1.012 is 0.4048. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.936 is 0.01872. The sum is 0.88252 multiplied by the DWC conversion factor of $58.31 for a MAR of $51.46. 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 $39.66 at 4 units is $158.64. This amount multiplied by 4 visits is $634.56.
   - Procedure code 97140, November 5, 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, 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. This amount multiplied by 4 visits is $291.6.
   - Procedure code 97112, November 5, 2018, has a Work RVU of 0.5 multiplied by the Work GPCI of 1.02 is 0.51. The practice expense RVU of 0.47 multiplied by the PE GPCI of 1.012 is 0.47564. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.936 is 0.01872. The sum is 1.00436 multiplied by the DWC conversion factor of $58.31 for a MAR of $58.56. 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. This code has the highest PE. The first unit is paid at $58.56. This amount multiplied by 4 visits is $234.24.

- Procedure code G0283, November 5, 2018, has a Work RVU of 0.18 multiplied by the Work GPCI of 1.02 is 0.1836. The practice expense RVU of 0.23 multiplied by the PE GPCI of 1.012 is 0.23276. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.936 is 0.00936. The sum is 0.42572 multiplied by the DWC conversion factor of $58.31 for a MAR of $24.82. 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 $18.04. This amount multiplied by 4 visits is $72.16.

3. The total allowable reimbursement for the billed services is $1,232.56. The insurance carrier paid a total of $1,156.50 for all billed services. The amount due to the requestor is $76.06. 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 $76.06.

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 $76.06, 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 22, 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 division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Include a copy of this *Medical Fee Dispute Resolution Findings and Decision*** together with any other information required by 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.