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
Millennium Chiropractic

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-19-3231-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
February 22, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All procedures in dispute were pre-authorized, as shown in the attached pre-authorization letters. The amounts billed were billed at MAR, according to our best understanding of what MAR was at that time. All billings were billed appropriately and in 100% accordance with all appropriate rules and laws."

Amount in Dispute: $646.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual is not questioning the medical necessity of the services rendered. 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

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 19, 2018 through March 22, 2018	Physical therapy services	$646.51	$0.00

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 the requirements for prior authorization.
4. 28 Texas Administrative Code §133.307 defines timeliness of requests for MFDR.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - PNFC – The reimbursement is based on the CMS physician fee schedule non-facility site of service rate
   - Z710 – the charge for this procedure exceeds the fee schedule allowance
   - X170 – Pre-authorization was required, but not requested for this service per DWC Rule 134.600

Issues

1. Is the insurance carrier's position supported?
2. Was the request for MFDR submitted within one year from DOS?
3. Is the insurance carrier's denial for lack of pre-authorization supported for date of service March 22, 2018?
4. Does the CMS multiple procedure payment reduction apply to the disputed services?
5. What is the Maximum Allowable Reimbursement(MAR) for dates of service February 21st through March 21st 2018?
6. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $646.51 for physical therapy services rendered from February 19, 2018 – March 22, 2018. The respondent states in their response, "The reductions that are applied are related to the CMS limitations on the number of physical therapy units allowed per day."

   Review of the submitted documentation found insufficient evidence to support the "CMS limitations" cited by the respondent. The carrier's position is not supported.

2. The first date of service listed on the DWC060 is February 19, 2018. The date the dispute was received in the MFDR section was February 22, 2019. 28 Texas Administrative Code 133.307 (c) (1) (A) states in pertinent part:

   > Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
   >
   > (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.
   >
   > (B) A request may be filed later than one year after the date(s) of service if:
   >
   > (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;

   Review of the submitted document found no exception to the timely filing requirement of the above rule. Date of service February 19, 2019 will not be considered in this request for MFDR.

3. For date of service March 22, 2018, the carrier denied for lack of pre-authorization and states, "The 12 visits that were approved were used from DOS 2/19/18 thru 3/21/18. The denial for DOS 3/22/18 stands as this was the 13th visit and the provider did not get additional UM approval for treatment." Review of the submitted documentation finds approval dated February 16th 2018 for 6 visits from 2/14/2018 to 4/16/2018 of "chiropractic therapy for the right shoulder with CPT codes 98943, 97110 and 97140 only".
   There is an additional approval dated March 9th 2018 which states "Given the improvement noted as result of the initial 6 treatments…The request is modified to 6 visits over 4 weeks" from 03/07/18 to 5/17/18. The requestor had approval for a total of 12 visits.

Submitted documentation shows the respondent paid for six visits on February 19th, 21st, 22nd ,26th March 1st and March 5th under the first preauthorization. Documentation also supports that the respondent paid for six visits on March 7th , 8th , 12th , 14th , 15th and 21st under the second preauthorization.

The respondent's denial is supported as the requestor had only had 12 visits authorized and date of service March 22nd, 2018 was the thirteenth.

4. 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; 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.

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 for four units of CPT code 97110, one or two units of CPT code 97140, 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 97110 has the highest PE payment for each date of service in dispute, so the first unit of 97110 should be paid at the full amount. Reimbursement for the services other than the first unit of 97110 will have the multiple procedure payment reduction applied.

5. 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 Irving, Texas in February and March of 2018. The formula for reimbursement is the Division of Workers Compensation Conversion Factor for 2018 divided by the Medicare Conversion Factor for 2018 multiplied 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 and 97140 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	$31.55	$24.25	0.4
97140	Manual therapy	$28.72	$22.33	0.35

For each of the below dates of service the reimbursement for the first unit of 97110 is DWC Conversion Factor 58.31 divided by the Medicare Conversion Factor 35.996 multiplied by $31.55 = $51.10.

For each of the below dates of service additional units of 97110 are reimbursable at DWC Conversion Factor 58.31 divided by the Medicare Conversion Factor 35.996 multiplied by the reduced amount of $24.25 = $39.28.

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 35.996 multiplied by the reduced amount of $22.33 = $36.17.

The Maximum Allowable Reimbursement (MAR) for dates of service February 21st through March 21st 2018 is shown below

Date of service	CPT Code	Units	MAR Per Unit	Total MAR
21-Feb-18	97140	2	$36.17 per unit	$72.34
21-Feb-18	97110	4	$51.10 1st unit $39.28 2nd – 4th units	$168.94
22-Feb-18	97140	1	$36.17 per unit	$36.17
22-Feb-18	97110	4	$51.10 1st unit $39.28 2nd – 4th units	$168.94
26-Feb-18	97140	1	$36.17 per unit	$36.17
26-Feb-18	97110	4	$51.10 1st unit $39.28 2nd – 4th units	$168.94
1-Mar-18	97140	2	$36.17 per unit	$72.34
1-Mar-18	97110	4	$51.10 1st unit $39.28 2nd – 4th units	$168.94
5-Mar-18	97140	2	$36.17 per unit	$72.34
5-Mar-18	97110	4	$51.10 1st unit $39.28 2nd – 4th units	$168.94
8-Mar-18	97140	2	$36.17 per unit	$72.34
8-Mar-18	97110	4	$51.10 1st unit	$168.94

			$39.28 2nd – 4th units	
12-Mar-18	97140	2	$36.17 per unit	$72.34
12-Mar-18	97110	4	$51.10 1st unit $39.28 2nd – 4th units	$168.94
14-Mar-18	97140	2	$36.17 per unit	$72.34
14-Mar-18	97110	4	$51.10 1st unit $39.28 2nd – 4th units	$168.94
15-Mar-18	97140	2	$36.17 per unit	$72.34
15-Mar-18	97110	4	$51.10 1st unit $39.28 2nd – 4th units	$168.94
21-Mar-18	97140	2	$36.17 per unit	$72.34
21-Mar-18	97110	4	$51.10 1st unit $39.28 2nd – 4th units	$168.94
Total				**$2,340.46**

6. The total allowable reimbursement for dates of service February 21st through March 2st is $2.340.46. The insurance carrier paid $2,658.89. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		June 13 , 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.