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
Travelers Indemnity Co of America

MFDR Tracking Number
M4-19-3321-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
February 27, 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: $722.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider performed and billed more than 4 units (1 hour) of physical therapy per date of service. The Medicare edits limit physical therapy billing and reimbursement to no more than 4 units (1 hour) per day. The Carrier reimbursed the Provider consistent with the Medicare edits. As the disputed services were properly reimbursed, the Provider is not entitled to additional reimbursement for the disputed services."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 16 – 27, 2018	Outpatient Therapy Services	$722.04	$441.92

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 preauthorization of healthcare rules.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 119 – Benefit maximum for this time period or occurrence has been reached
   - 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules

Issues

1. Is the carrier's position supported?
2. Is the carrier's reduction of payment supported?
3. What rule(s) are applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient therapy services performed from November 16 - 27, 2018. The insurance carrier limited the number of units based on "benefit maximum for the time period reached." The respondent states in their response, "The Carrier reimbursed the Provider consistent with the Medicare edits."

   Review of the submitted documentation found insufficient evidence to support the "Medicare edits" cited by the respondent. Further review found a utilization review letter dated September 12, 2018 that prior authorized physical therapy for the right shoulder, neck with CPT codes- 97110, 97140, and 97112 for dates of service 9/12/18-10/12/18. This authorization did not limit the number of authorized units.

   28 TAC 134.203 (a) (7) states in pertinent part,

   > 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,

   > 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;

   Based on the above, the prior authorization is effect without limit to the number of units. The carrier's position will not be considered in this review.

2. The carrier reduced the allowed amounts as 163 – "The charge for this procedure exceeds the unit value and/or the **multiple procedure rules**." 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

   The reduction based on the Medicare Multiple Procedure Payment Reduction (MPPR) found in the CMS Claims Processing Manual 100-04, Chapter 5, section 10.7 at www.cms.gov does apply and was used in the calculation of the maximum allowable reimbursement shown below.

3. 28 Texas Administrative Code §134.203 (c) (1) which states,

   > 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 is calculated by the DWC Conversion Factor of 58.31/Medicare Conversion Factor 35.9996 multiplied by the Medicare allowable. **To ensure the appropriate application of the MPPR reductions all services billed for each date will be calculated**. The calculation is as follows:

- Procedure code 97110 billed November 16, 2018 for 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 $24.48. 58.31/35.9996 x $31.77 = $51.46. 58.31/35.9996 x $24.48 x 3 = $118.95. $51.46 + $118.95 = $170.41
- Procedure code 97140 billed November 16, 2018 for two units has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of $22.50. 58.31/35.996 x $22.50 x 2 = $72.89
- Procedure code 97112 billed November 16, 2018 has a PE of 0.47 not the highest for this date and will be paid at the reduced rate of $27.60. 58.31/35.9996 x $27.60 = $44.70
- Procedure code G0283 billed November 16, 2018 has a PE of 0.23 not the highest for this date and will be paid at the reduced rate of $11.14. 58.31/36.996 x $11.14 = $18.04
- Procedure code 97110 billed November 19, 2018 for 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 $24.48. 58.31/35.9996 x $31.77 = $51.46. 58.31/35.9996 x $24.48 x 3 = $118.95. $51.46 + $118.95 = $170.41
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- Procedure code G0283 billed November 19, 2018 has a PE of 0.23 not the highest for this date and will be paid at the reduced rate of $11.14. 58.31/36.996 x $11.14 = $18.04
- Procedure code 97110 billed November 21, 2018 for 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 $24.48. 58.31/35.9996 x $31.77 = $51.46. 58.31/35.9996 x $24.48 x 3 = $118.95. $51.46 + $118.95 = $170.41
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The total allowable reimbursement for the services in dispute is $1,224.16. The carrier paid $782.24. The remaining balance of $441.92 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 $441.92.

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 $441.92, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		March 27, 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.