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
Accident Fund National Insurance

MFDR Tracking Number
M4-19-3442-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
March 13, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please process our request for reconsideration for these services and bills were CERTIFIED and properly billed and documented."

Amount in Dispute: $350.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receiving the dispute, Accident Fund had the original bill audit reviewed and has determined that for DOS 12/6/18, there was an underpayment of $60.82, for a total allowance of $237.73, the same allowance as provided for DOS 12/14/18. Accident Fund will issue additional reimbursement in that amount to Patient Care Injury Clinic. Accident Fund stands by its original audit in all other respects."

Response Submitted by: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 6 – 14, 2018	Physical therapy services	$350.96	$201.46

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:
    - 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
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

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 350.96 for physical therapy services rendered December 6 and 14, 2018. The carrier denied/reduced the services in dispute as, 119 – "Benefit maximum for this time period or occurrence has been reached" and 168 – "Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services."

   Review of the submitted documentation found certification of "Active Physical Medicine 3xWkx4Wks Cervical 97110 97140 97112. Certified quantity 12 physical therapy. State date 10/30/18. End date 12/30/18." No limits on the number of units of each type therapy was noted. The Division finds insufficient evidence to support the basis of the "benefit maximum or daily maximum allowance." The insurance carriers' denial is not supported. The services in dispute will be reviewed per applicable fee guideline.

2. The applicable fee is found in 28 TAC 134.203 (b) (1) which 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 for four units of CPT code 97110, two units of CPT code 97140, one unit of code 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 97112 should be paid at the full amount. Reimbursement of the services other than 97112 will have the multiple procedure payment reduction applied. The calculation of all services billed on each date of service will be calculated to ensure the appropriate application of the MPPR reduction.

3. The reimbursement guideline is found in 28 Texas Administrative Code 134.203 (c) which 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 December 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 Houston 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
97112	Neuromuscular reeducation	$36.16	$27.60	0.47
97140	Manual therapy	$28.88	$22.50	0.35
G0283	Elec stim other than wound	$15.13	$11.14	0.23

   For each of the below dates of service 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 code 97112 is reimbursable at DWC Conversion Factor 58.31 divided by the Medicare Conversion Factor 35.9996 multiplied by the full amount of $36.16 = $58.57

   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 dates of service code G0283 is 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 December 6 and 14, 2018 is shown below

Date of service	Submitted Code	Units	MAR per unit	Total MAR
December 6, 2018	97110	4	$24.48 x 4 = $158.60	$158.60
December 6, 2018	97140	2	$22.50 x 2 = $72.89	$72.89
December 6, 2018	97112	1	$36.16	$58.57
December 6, 2018	G0283	1	$11.14	$18.04
December 14, 2018	97110	4	$24.48 x 4 = $158.60	$158.60

December 14, 2018	97140	2	$22.50 x 2 = $72.89	$72.89
December 14, 2018	97112	1	$36.16	$58.57
December 14, 2018	G0283	1	$11.14	$18.04
		Total		$616.20

4. The total allowable reimbursement for the services in dispute is $616.20. The carrier made the following payments;
    - January 2, 2019 - $176.96
    - January 4, 2019 - $237.78

   For a total of $414.74. The remaining balance of $201.46 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 $201.46.

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

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 12, 2019 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.