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 PA

Respondent Name
SENTINEL INSURANCE COMPANY LTD

MFDR Tracking Number
M4-19-3695-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
April 3, 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: $621.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dates of service in dispute were processed in accordance with Medicare guidelines."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 8, 2018 to December 28, 2018	Physical Therapy	$621.81	$157.13

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
   - 168 – BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES
   - 309 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 18 – EXACT DUPLICATE CLAIM/SERVICE
   - 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.

- 247 – A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE
- 1115 - WE FIND THE ORIGINAL REVIEW TO BE ACCURATE AND ARE UNABLE TO RECOMMEND ANY ADDITIONAL ALLOWANCE
- 1002 – DUE TO AN ERROR IN PROCESSING THE ORIGINAL BILL, WE ARE RECOMMENDING FURTHER PAYMENT BE MADE FOR THE ABOVE NOTED PROCEDURE.

Issues

1. Is the injured employee subject to a benefit maximum?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason 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

   While the division has adopted Medicare *payment* policies in administering the workers' compensation medical fee guidelines, it has not adopted Medicare's *benefit* limitations. Texas Labor Code §408.021(a) entitles injured employees "to all health care reasonably required by the nature of the injury as and when needed."

   The respondent did not present information to support that the injured employee or the disputed services were subject to a "benefit maximum," "maximum unit value," or "maximum daily allowance." This denial reason is not supported. The services will therefore be reviewed for reimbursement in accordance with division fee guidelines.

2. This dispute regards physical therapy with reimbursement 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.

   Reimbursement is calculated as follows:

   - Procedure code 97110 (November 8, December 3, December 11, December 13, December 28, 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 per visit, for 5 visits is $793.20. The insurance carrier paid $793.20, leaving an amount due of $198.45.
   - Procedure code 97140 (December 3 and December 11, 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 per visit, for 2 visits is $145.80. The insurance carrier paid $187.12, resulting in an overpayment of $41.32.

   The total allowable reimbursement for the disputed services is $939.00. The insurance carrier paid $781.87. The amount due is $157.13. 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 $157.13.

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 $157.13. plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	April 26, 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.