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
Harris County

MFDR Tracking Number
M4-19-4353-01

Carrier's Austin Representative
Box Number 21

MFDR Date Received
June 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: $361.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent paid for the number of units that were preauthorized and consistent with the ODG and CMS guidelines. For each date of service, Respondent paid for three units of 97110, one unit of 97112, and one unit of G0283."

Response Submitted by: Thornton, Biechlin, Reynolds, & Guerra

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 14, 2018	97110, 97140, 97112, G0283	$361.02	$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 fee guidelines for professional medical services.
3. 28 Texas Administrative Code §134.600 details requirements of prior authorization.
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 the multiple procedure rules

- 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

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the respondent's position supported?

Findings

1. The requestor is seeking $361.02 for physical therapy services rendered August 14, 2018. The insurance carrier denied stating "benefit maximum for this time period or occurrence has been reached."

   Review of the submitted "Preauthorization Determination Letter Amended 8/2/2018 found, "…additional two sessions of physical therapy at two timer per week is PARTIAL PREAUTHORIZATION for home exercise instructions up to **four units** per session."

   Review of the submitted medical bill found a total of eight units billed which exceeds the authorized units. The insurance carriers' denial is supported.

2. Respondent paid for three units of 97110, one unit of 97112, and one unit of G0283.

   Review of the submitted Explanation of Benefits from IMO dated August 22, 2018 found a total payment of $195.56. The maximum allowable reimbursement for the authorized services is as follows:

   - Procedure code 97112 has the highest practices expense and receives full reimbursement of the allowable of $36.16. DWC Conversion Factor/Medicare Conversion Factor x Allowable or 58.31/35.9996 x $36.16 = $58.57. The carrier paid $58.57 no additional payment is due.
   - Procedure code 97110 is paid at the reduced allowable of $24.48. 58.31/35.9996 x $24.48 x 3 = $118.95. The carrier paid $118.95 no additional payment is due.
   - Procedure code G0283 is paid at the reduced allowable of $11.14. 58.31/35.9996 x $11.14 = $18.04. The carrier paid $18.04 no additional payment is due.

   Based on the above, no additional payment is due.

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

Signature	Medical Fee Dispute Resolution Officer	July 9, 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.