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
ELITE HEALTHCARE FORT WORTH

Respondent Name
TRAVELERS INDEMNITY COMPANY OF CONNECTICUT

MFDR Tracking Number
M4-19-4360-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
June 4, 2019

Response Submitted By
Travelers

REQUESTOR'S POSITION SUMMARY

"CARRIER IS NOT PAYING ACCORDING TO AUTHORIZATION OUR FACILITY RECEIVED REGARDING THIS PATIENT."

RESPONDENT'S POSITION SUMMARY

"With regards to CPT code 97110, the Carrier has reviewed the documentation and determined the Provider was properly reimbursed. … With regards to CPT code 97140, the Carrier has reviewed the documentation and determined the Provider is entitled to reimbursement for the disputed service. Reimbursement is being issued …"

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 4, 2019	Physical Therapy Services	$218.44	$58.34

AUTHORITY

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
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - B12 – SERVICES NOT DOCUMENTED IN PATIENT'S MEDICAL RECORDS.
   - 947 – UPHELD. NO ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED

Issues

1. Are the disputed services or the injured employee subject to any benefit maximum?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code:
   - 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 Labor Code's guarantee of medical benefits thus supersedes any conflicting Medicare benefit policy.

   Furthermore, Rule §134.203(a)(7) states, "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."

   The Labor Code and division rules have further adopted specific provisions regarding authorization, utilization review and dispute processes for medical necessity that supersede any conflicting Medicare policies regarding maximum units.

   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 medical services 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.

   Medicare's multiple-procedure payment reduction (MPPR) policy requires payment in full for the first unit of therapy with the highest practice expense. Payment is reduced by 50% of the practice expense for each extra therapy unit (codes with multiple-procedure indicator 5) provided on the same day.

   Reimbursement is calculated as follows:

   - Procedure code 97110 has a Work RVU of 0.45 multiplied by the Work GPCI of 1.007 is 0.45315. The practice expense RVU of 0.4 multiplied by the PE GPCI of 0.986 is 0.3944. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.747 is 0.01494. The sum is 0.86249 multiplied by the DWC conversion factor of $59.19 for a MAR of $51.05. The PE for this code is not the highest; payment is reduced by 50% of the practice expense. The PE reduced rate is $39.38 at 4 units is $157.52.
   - Procedure code 97140 has a Work RVU of 0.43 multiplied by the Work GPCI of 1.007 is 0.43301. The practice expense RVU of 0.35 multiplied by the PE GPCI of 0.986 is 0.3451. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.747 is 0.00747. The sum is 0.78558 multiplied by the DWC conversion factor of $59.19 for a MAR of $46.50. The PE for this code is not the highest; payment is reduced by 50% of the practice expense. The PE reduced rate is $36.29 at 2 units is $72.58.

   The total allowable reimbursement for the two disputed services is $230.1. The insurance carrier paid a total of $171.76 towards the 2 disputed line items (including a subsequent payment of $93.00, issued after the carrier's denial of the request for reconsideration and the filing of the request for MFDR with the division).

   The amount remaining due is $58.34. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the division finds additional payment is due. As a result, the amount ordered is $58.34.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, the division finds the requestor is entitled to additional reimbursement. The division hereby ORDERS the respondent to remit to the requestor $58.34, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	August 30, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). 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 field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute 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.