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
YNES R. SAMUELS, DC

Respondent Name
METROPOLITAN TRANSIT AUTHORITY HARRIS CO

MFDR Tracking Number
M4-19-4625-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 24, 2019

Response Submitted By
Flahive, Odgen & Latson, Attorneys at Law, PC

REQUESTOR'S POSITION SUMMARY

"These charges are part of the initial two weeks of therapy following the surgical procedure…"

RESPONDENT'S POSITION SUMMARY

"The services required preauthorization and none was obtained… the other four dates of physical therapy did exceed the ODG."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 13, 2019 to March 20, 2019	Physical Therapy Services	$960.00	$692.08

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. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
4. 28 Texas Administrative Code §137.100 sets out the division's treatment guidelines.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W3 – Additional reimbursement made on appeal/reconsideration.
   - 193 – Original payment decision is being maintained. this claim was processed properly the first time.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 197 – Payment denied/reduced for absence of precertification/authorization.
     - The treatment is outside or exceeds the ODG; therefor preauthorization is required.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
    - 197 – Payment denied/reduced for absence of precertification/authorization.

    With additional payment remittance advice:
    - The treatment is outside or exceeds the ODG; therefor preauthorization is required.

    28 Texas administrative Code §137.100(d) states the insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines unless:

    (1) the treatment(s) or service(s) were provided in a medical emergency; or

    (2) the treatment(s) or service(s) were preauthorized in accordance with §134.600 or §137.300 of this title.

    28 Texas Administrative Code §134.600(p)(5)(C) states that non-emergency health care requiring preauthorization includes physical and occupational therapy services…

    > except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following: (i) the date of injury; or (ii) a surgical intervention previously preauthorized by the insurance carrier

    The provider asserts "These charges are part of the initial two weeks of therapy following the surgical procedure…" Review of the submitted information finds the disputed services were rendered within the first two weeks immediately following an authorized surgical intervention. Accordingly, preauthorization was not required under Rule §134.600(p)(5)(C)(ii).

    However, the insurance carrier asserts that authorization was still required under Rule §137.100(d)(2), asserting further that the division's treatment guidelines recommend at most 2 visits under the given circumstances.

    The division's treatment guidelines are established in Rule §137.100(a) which requires that:

    > Health care providers shall provide treatment in accordance with the current edition of the Official Disability Guidelines - Treatment in Workers' Comp, excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines) …

    Review of the submitted EOBs, medical bill and medical records finds the injured employee's diagnosis includes "sprain of ligaments of lumbar spine." For diagnosis of lumbar sprains and strains, division treatment guidelines recommend physical therapy for "10 visits over 8 weeks."

    The carrier contends division treatment guidelines recommend 1-2 visits over 1 week for "post-injection treatment" (the procedure performed in the injured employee's surgical intervention). However, the respondent *omits* the crucial context for that recommendation: the guideline regarding "post-injection treatment" is specified *only* for treating diagnoses involving "intervertebral disc disorders without myelopathy."

    The records do not support the employee was diagnosed with or treated for an intervertebral disc disorder, but rather for lumbar sprain. The division thus finds the disputed services do not meet the criteria for the disc disorder recommendation of 1-2 visits over 1 week, which the carrier cites as the rationale for denying payment.

    Because the employee's diagnosis involves lumbar sprain, the appropriate treatment guideline recommends "10 visits over 8 weeks." The division thus concludes the disputed services were within and recommended by division treatment guidelines. Per Rule §134.600(p)(5)(C)(ii), preauthorization was *not* required for physical therapy during the first two weeks following a surgical intervention — the period within which these services were rendered.

    The division thus concludes that the insurance carrier's denial reasons are unsupported and without merit. The services will therefore be reviewed for payment in accordance with division rules and 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 the first unit of the therapy code with the highest practice expense be paid in full. Payment is reduced by 50% of the practice expense for each extra unit of therapy (codes with multiple-procedure indicator 5) provided on the same date.

   Reimbursement is calculated as follows:

   - Procedure code 97110 (March 13, March 15, March 19, and March 20, 2019) 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 $59.19 for a MAR of $52.24. Per Medicare's multiple therapy procedure policy, payment is reduced by 50% of the practice expense for each extra therapy unit after the first unit performed each date. The first unit is paid at $52.24. The PE reduced rate is $40.26, at 3 units is $120.78. The subtotal for 4 units is $173.02. The total for 4 visits is $692.08.

   The total allowable reimbursement for the disputed services is $692.08. The insurance carrier paid $0.00. The amount due is $692.08. 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 that additional payment is due. As a result, the amount ordered is $692.08.

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 $692.08, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	July 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.

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.