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
VALLEY FORGE INSURANCE COMPANY

MFDR Tracking Number
M4-19-4896-01

Carrier's Austin Representative
Box Number 57

MFDR Date Received
July 16, 2019

Response Submitted By
Law Office of Brian J. Judis

REQUESTOR'S POSITION SUMMARY

"THIS IS AN INCORRECT DENIAL FROM THE CARRIER. CARRIER IS NOT PAYING ACCORDING TO AUTHORIZATION OUR FACILITY RECEIVED REGARDING THIS PATIENT."

RESPONDENT'S POSITION SUMMARY

"The Carrier asserts that the appropriate payments have been made in accordance with the Texas Fee Guidelines and Medicare Edits."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 26, 2019	Physical Therapy Services: 97110, 97140	$195.10	$128.00

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 §133.240 sets out provisions regarding medical payments and denials.
4. Texas Labor Code §408.021 entitles an injured employee to all required health care as and when needed.
5. 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
   - 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.
   - 536 – THESE CHARGES HAVE ALREADY BEEN BILLED AND PAID FOR ACCORDING TO FEE SCHEDULE AND/OR REASONABLE GUIDELINES. NO FURTHER PAYMENT IS DUE.
   - B12 – SERVICES NOT DOCUMENTED IN PATIENT'S MEDICAL RECORDS.
   - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
   - 1014 - THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.

Issues

1. Did the health care provider document the disputed services in the medical records?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code B12 – "Services not documented in patient's medical records."

   Review of the submitted medical records finds that procedure code 97110 (therapeutic exercises) is sufficiently documented in the therapy note, with specific exercises and the minutes performed for each detailed on the attached flow sheets. The submitted records support the 4 timed units billed for this service.

   Review of the submitted therapy note finds that the components of procedure code 97140 (manual therapy) are sufficiently documented in the therapy note, indicating a minimum of 35 minutes performed, to support the 2 timed units billed for this service.

   The division concludes the medical records support the services as billed. The carrier's denial reason is not supported.

2. 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."

   Moreover, 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 division has adopted specific provisions regarding preauthorization, utilization review and dispute processes for medical necessity that supersede Medicare policies regarding medically unlikely edits or maximum units.

   The respondent cites *Medicare Claims Processing Manual*, Chapter 5, *Part B Outpatient Rehabilitation and CORF/OPT Services*, §20.2, D. "Specific Limits for HCPCS" as Medicare policy supporting the carrier's reduction of payment, quoting, "The following codes may be billed, when covered, only at or below the number of units indicated on the chart per treatment day."

   The division takes notice that the cited Medicare policy further states "When higher amounts of units are billed than those indicated in the table below, the units on the claim line that exceed the limit shall be denied as medically unnecessary." Pursuant to Rule §134.203(a)(7), above, provisions in the Labor Code and division rules regarding preauthorization and medical necessity disputes supersede this conflicting Medicare payment policy.

   Furthermore, review of that chart in the referenced policy finds that the services in dispute, procedure codes 97110 and 97140, are not listed as subject to the payment policy.

   Moreover, Rule §133.240(b) states, "the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments)." The above Medicare policy cited by the respondent is therefore not applicable to any services that are preauthorized. Review of the submitted information finds the disputed services were preauthorized for the number of units billed. The carrier's position is thus without merit.

   The insurance carrier failed to support their denial reasons based on "benefit maximum," "maximum unit value" or "daily maximum allowance." The disputed services will therefore be reviewed for payment in accordance with division rules and fee guidelines.

3. 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 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 for this date; 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 for this date; 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 these disputed services is $230.10. The insurance carrier paid $102.10. The amount remaining due is $128.00. This amount is recommended.

Conclusion

For the reasons above, the division finds that additional payment is due. As a result, the amount ordered is $128.00.

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 $128.00, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

______________________	Grayson Richardson	August 9, 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.