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
KTS Partners, Inc

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-20-0422-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
October 17, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Your EOR states 97110 does not have an allowance in the Texas Medicaid FS. This is incorrect as TMHP prices 97110 at $33.75 per unit for Home Health."

Amount in Dispute: $1,140.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill for 6/24/2019 was reviewed no payment is due at this time as the provider did not billed properly."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 24, 2019	97110	$1,140.00	$126.56

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 billing requirements for physical therapy services.
3. 28 Texas Administrative Code §134.215 sets out the reimbursement guidelines for home health services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 4142 – The billed service has no allowance in Texas Medicaid Home Health Agency fee schedule

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What rule is applicable to fee guideline?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for physical therapy services rendered June 24, 2019. The insurance carrier denied disputed services based on the modifier used.

   28 TAC §134.203 (b) requires Texas workers' compensation system participants to apply Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   Review of the Medicare payment policy in the Medicare Claims Processing Manual Chapter 5, Section 20.1 at www.cms.gov, regarding modifiers states,

   > *The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered:*
   >
   > • *GN Services delivered under an outpatient speech-language pathology plan of care;*
   >
   > • *GO Services delivered under an outpatient occupational therapy plan of care; or,*
   >
   > • *GP Services delivered under an outpatient physical therapy plan of care.*

   Review of the submitted medical bill found the submission of 97110, GP. Based on the above, the insurance carrier's denial is not supported. The disputed services will be reviewed per applicable fee guideline.

2. 28 TAC §134.215 states, the maximum allowable reimbursement (MAR) amount for home health services provided through a licensed home health agency shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies.

   The Texas Medicaid fee schedule amount for Code 97110 is $33.75 per unit.

   The allowable of $33.75 x 125% = $42.19 x 3 = $126.56 for date of service June 24, 2019.

3. The total allowable for the services in dispute is $126.56. The insurance carrier previously made no payment. The allowable of $126.56 is due to the requestor.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC 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 requestor has established payment is due. As a result, the amount ordered is $126.56.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $126.56, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		November 21, 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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.