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
Baptist St Anthonys Health

Respondent Name
Liberty Mutual

MFDR Tracking Number
M4-20-0744-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
November 20, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: None submitted.

Amount in Dispute: $123.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance Division of Workers' Compensation Acts and Rules."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 9 – 30, 2019	Outpatient Therapy Services	$123.56	$36.93

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 §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment

codes:

- 163 – The charge for this procedure exceeds the unit value and/or multiple procedure rules
- 170 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting
- 877 – Reimbursement is based on the contracted rate
- 5917 – Pre-authorization was required but not requested for this service per DWC Rule 134.600

Issues

1. Is the reduction based on a contract supported?
2. Is the insurance carrier's denial of code 97035 and 97039 supported?
3. Is the carrier's reduction of payment supported?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced the allowed amount of the disputed service based on a contract. The carrier did not provide convincing evidence to support the services are subject to a contract. This reduction will not be considered in this review.

2. The physical therapy service Code 97039 rendered on July 18, 2019 and Code 97035 on July 25, 2019 were denied by the insurance carrier as lacking prior authorization. 28 TAC 134.600 (p) lists all non-emergency services that require prior authorization. Physical therapy is listed as requiring prior authorization.

   Review of the submitted documentation found insufficient evidence to support the denied services were prior authorized. The insurance carrier's denial is supported.

3. The requestor is seeking additional reimbursement for outpatient therapy services performed from July 9 - 30, 2019. The carrier reduced the allowed amount based on the multiple procedure discounts.

   28 TAC 134.403 applies to outpatient hospital services. Section (h) requires when Medicare reimburses using other Medicare fee schedules, reimbursement is made using the applicable Division Fee Guideline in effect for that service on the date was provided.

   The applicable DWC fee guideline for physical therapy is 28 TAC §134.203 (b) (1) which requires the application of Medicare payment policies applicable to professional services.

   Review of the Medicare policies finds multiple procedure payment reduction (MPPR) applies to the Practice Expense (PE) of certain time-based physical therapy codes when more than one unit or procedure is provided to the same patient on the same day.

   The MPPR policy allows for full payment for the unit or procedure with the highest Practice Expense (PE) payment factor and for subsequent units the Practice Expense (PE) payment factor is reduced by 50 percent.

   Review of the submitted medical bill provided indicates that four procedures were billed by the health care provider. In order to determine whether the MPPR applies to the service in dispute, the DWC must rank all the services provided in July 2019 by their PE payment factor.

   Here is a chart ranking the PE payment for each of the codes billed by the health care provider.

CODE	PRACTICE EXPENSE	ALLOWED AMOUNT	Medicare Policy
97110	**0.4**	**$30.31** $23.55	**Highest PE MPPR doesn't apply** Second unit
97140	0.35	$21.70	

97161	1.15	$86.91	Only service date of service for July 9, 2019

The *MPPR Rate File* that contains the payments for 2019 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

- MPPR rates are published by carrier and locality.
- The services were provided in Amarillo Texas.
- The carrier code for Texas is 4412 and the locality code for Amarillo is 99.

The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR

Applicable 28 TAC 134.203(h) states that the total reimbursement is the lesser of the maximum allowable reimbursement (MAR) and the billed amount.

Date of Service	Code	Units	Medicare Payment	DWC Conversion Factor divided by Medicare Conversion Factor or 59÷36.0391	Billed Amount	Lesser of MAR and billed amount
July 12, 2019	97110	2	$30.31 $23.55	$49.78 + $38.68 = $88.46	$354.00	$88.46
July 16, 2019	97110	1	$30.31	$49.78	$177.00	$49.78
July 18,2019	97110	1	$30.31	$49.78	$177.00	$49.78
July 23, 2019	97110	1	$30.31	$49.78	$177.00	$49.78
July 25, 2019	97110	2	$30.31 $23.55	$49.78 + $38.68 = $88.46	$354.00	$88.46
July 30, 2019	97110	2	$30.31 $23.55	$49.78 + $38.68 = $88.46	$354.00	$88.46
July 16, 2019	97140	2	$21.10	$69.31	$408.00	$69.31
July 18, 2019	97140	1	$21.10	$34.65	$204.00	$34.65
July 23, 2019	97140	3	$21.10	$103.96	$612.00	$103.96
July 25, 2019	97140	1	$21.10	$34.65	$204.00	$34.65
July 9, 2019	97161	1	$86.91	$142.74	$368.00	$142.74
					Total	$800.03

4. The total allowable DWC fee guideline reimbursement is $800.3. The insurance carrier paid $761.37 the remaining balance of $38.93 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. The amount ordered is $36.93.

ORDER

information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $36.93, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		January 16, 2020
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.