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
Seton Medical Center Harker Heights

Respondent Name
Liberty Mutual Fire Insurance Co

MFDR Tracking Number
M4-20-0768-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
November 25, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code..."

Amount in Dispute: $79.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...denial for 97035 as when a provider bills for modality... ...bill review will disallow the modality code."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 29, 2019 to May 22, 2019	Outpatient physical therapy	$79.23	$35.24

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 therapy.
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 the multiple procedure rule
   - 170 – Reimbursement is based on the physician fee schedule

- 246 – This procedure is inappropriately billed. It should only be billed in conjunction with appropriate required code.

Issues

1. Is the insurance carrier's reasons for reduction of payment supported?
2. What rule is applicable to reimbursement?
3. Is the insurance carrier's denial of payment supported?

Findings

1. The requestor is seeking additional reimbursement for outpatient therapy services performed from April 29, 2019 to May 22, 2019. The carrier denied the code for the Code 97035 – Application of modality, ultrasound as inappropriately billed. The respondent's states in their position statement billing a modality code (97035) with other submitted code (97110) causes a denial.

   28 TAC 134.403 (d) states Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided for coding, billing, reporting, and reimbursement of health care.

   Review of the NCCI coding edits and the Medicare Payment Policy in Chapter Five of the Claims Processing Manual found at www.cms.gov, found insufficient evidence to support this denial. Code 97035 will be reviewed per applicable fee guideline.

2. 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 two 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 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	1st Unit no MPPR Subsequent unit(s) MPPR applies
97035	0.17	$10.73	MPPR applies

   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 Harker Heights Texas.
   - The carrier code for Texas is 4412 and the locality code for Harker Heights 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 59.19 ÷36.0391	Billed Amount	Lesser of MAR and billed amount
May 22, 2019	97035	1	$10.73	$17.62	$301.00	$17.62
May 24, 2019	97035	1	$10.73	$17.62	$301.00	$17.62
April 29, 2019	97110	3	$30.31 $23.55	$49.78 + $77.36 = $127.14	$558.00	$127.14
April 30, 2019	97110	2	$30.31 $23.55	$49.78 + $38.68 = $88.46	$372.00	$88.46
May 1, 2019	97110	3	$30.31 $23.55	$49.78 + $77.36 = $127.14	$558.00	$127.14
May 3, 2019	97110	3	$30.31 $23.55	$49.78 + $77.36 = $127.14	$558.00	$127.14
May 6, 2019	97110	3	$30.31 $23.55	$49.78 + $77.36 = $127.14	$558.00	$127.14
May 8, 2019	97110	3	$30.31 $23.55	$49.78 + $77.36 = $127.14	$372.00	$127.14
May 10, 2019	97110	2	$30.31 $23.55	$49.78 + $38.68 = $88.46	$372.00	$88.46
May 13, 2019	97110	2	$30.31 $23.55	$49.78 + $38.68 = $88.46	$372.00	$88.46
May 15, 2019	97110	2	$30.31 $23.55	$49.78 + $38.68 = $88.46	$372.00	$88.46
May 20, 2019	97110	2	$30.31 $23.55	$49.78 + $38.68 = $88.46	$372.00	$88.46
					Total	$1,113.24

3. The total allowable DWC fee guideline reimbursement is $1,113.24. The insurance carrier paid $1,078.00. An additional payment of $35.24 is recommended.

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 $35.24.

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 $35.24, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

[redacted]	[redacted]	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.