



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

Texas Health Rockwall

Respondent Name

Liberty Insurance Corp

MFDR Tracking Number

M4-20-1327-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

January 23, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/Denied Physical Therapy rate."

Amount in Dispute: \$1111.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the denial for 97014/G0283 stands as Pre-Authorization was initially denied for this procedure code on May 13, 2019 by the Utilization Management team. ...Pricing for 97110 for DOS 5/22/2019 has been reviewed and is correct as 97110 for 2029 has RVU of .40 which makes is the highest code billed."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 22 – 31, 2019	Outpatient therapy services	\$1111.93	\$2.20

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:

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

Issues

1. Is the carrier’s denial and reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient therapy services performed in May 2019. The carrier denied Code G0283 based on lack of preauthorization. Review of the submitted documentation found this code was found to be not medically necessary at the time of utilization review. The insurance carrier’s denial is supported.

The carrier reduced the payment amount for Code 97110 and 97140 based on Medicare multiple procedure payment rules. 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. The insurance carrier’s reduction of payment is supported.

The Medicare 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 the MPPR allowable, the services provided are ranked by their PE expense shown below.

Code	Practice Expense	Allowed Amount	Medicare Policy
97110	0.4	\$31.58/\$24.27	MPPR applies on DOS May 22, 2019
97140	0.35	\$21.70	MPPR applies
97161	115	\$83.56	Highest on May 22, 2019
G0283	0.21	\$10.32	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 Rockwall, Texas.
- The carrier code for Texas is 4412 and the locality code is 99.

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

$$(\text{DWC Conversion Factor} \div \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$$

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 $59.19 \div 36.0391 = 1.64$	Billed Amount	Lesser of MAR and billed amount
May 22, 2019	97110	2	\$24.27	$\$24.27 \times 1.64 \times 2 = \79.61	\$325.00	\$79.61
May 31, 2019	97140	1	\$21.70	$\$21.70 \times 1.64 = \35.59	\$146.25	\$35.59
Total						\$115.20

- The total allowable DWC fee guideline reimbursement is \$115.20. The insurance carrier paid \$113.00. A balance of \$2.20 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 \$2.20.

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 \$2.20, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 6, 2020 Date
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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.