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
Patient Care Injury Clinic

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-21-0059-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 14, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted our bills and proper clinical documentation in a timely fashion. We feel that our facility should be paid according to workers compensation fee schedule guidelines."

Amount in Dispute: $1,085.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company has determined no further payment is due.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 26-29, 2020 June 24-26, 2020	Physical Therapy	$1,085.72	$895.52

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 fee guidelines for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out the requirements of prior authorization.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization
   - 119- Benefit maximum for this time period or occurrence has been reached
   - 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules

Issues

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

Findings

1. The requestor is seeking reimbursement of physical therapy services rendered in May and June of 2020. The insurance carrier denied the disputed services as benefit maximum reached or no prior authorization and reduced the billed charges based on multiple procedure rules.

   28 Texas Administrative Code §134.600 (p) (5) requires that non-emergency healthcare including physical therapy requires pre-authorization. Review of the submitted information finds that on April 21, 2020 prior authorization was given for physical therapy twelve visits from April 21 to July 21, 2020. A second authorization was given for physical therapy twice a week for four weeks from May 19, 2020 to August 19, 2020 for eight visits.

   While the submitted documentation indicates the number of visits and units were limited, insufficient evidence was submitted by the insurance carrier to support that these limits were exceeded. The submitted documentation does support the dates of service in dispute are within the authorized time frame, the disputed services will be reviewed per applicable fee guidelines.

2. 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 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. The insurance carrier's reduction of payment is supported.

   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	$24.69	MPPR applies
97140	0.35	$23.03	MPPR applies
97112	0.48	$36.85	No MPPR
G0283	0.2	$10.68	MPPR applies

   The *MPPR Rate File* that contains the payments for 2020 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 Houston, Texas.
   - The carrier code for Texas is 4412 and the locality code for Houston is 18.

   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. The calculation of the disputed services is found below

Date of Service	Code	Units	Medicare Payment	DWC Conversion Factor divided by Medicare Conversion Factor or 60.32÷36.0896	Billed Amount	Lesser of MAR and billed amount
May 26, 2020	97110	3	$24.69	$123.80	$160.68	$123.80
May 26, 2020	97140	1	$23.03	$38.49	$49.21	$38.49
May 26, 2020	97112	1	$36.85	$61.59	$61.55	$61.59
May 29, 2020	97110	3	$24.69	$123.80	$160.68	$123.80
May 29, 2020	97140	1	$23.03	$38.49	$49.21	$38.49
May 29, 2020	97112	1	$36.85	$61.59	$61.55	$61.59
June 24, 2020	97110	3	$24.69	$123.80	$160.68	$123.80
June 24, 2020	97140	1	$23.03	$38.49	$49.21	$38.49
June 24, 2020	97112	1	$36.85	$61.59	$61.55	$61.59
June 26, 2020	97110	3	$24.69	$123.80	$160.68	$123.80
June 26, 2020	97140	1	$23.03	$38.49	$49.21	$38.49
June 26, 2020	97112	1	$36.85	$61.59	$61.55	$61.59
					Total	$895.52

3. The total recommended reimbursement for the disputed services is $895.52 This amount 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. As a result, the amount ordered is $895.52.

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 $895.52, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 15, 2020 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.