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
KSF ORTHOPAEDIC CENTER

Respondent Name
TRUCK INSURANCE EXCHANGE

MFDR Tracking Number
M4-12-1110-01

Carrier's Austin Representative
Box Number 14

MFDR Date Received
December 9, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the Medicare Part B therapy manual, Medicare does not recognize PTA's as providers therefore services can only be billed by the supervising LPT. See attached copy of this requirement to verify we are billing correctly by not billing under our PTA's."

Amount in Dispute: $1,288.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier denied reimbursement on the grounds that the services were furnished by another provider other than the one under whose name the bill was submitted… Contrary to Division rule 133.20(e)(2), the services were not billed in her name. Therefore, reimbursement should not be recommended… Requestor is also not entitled to reimbursement for CPT code 97012 for the reason that CPT code 97012 was not one of the cods preauthorized."

Response Submitted by: Stone Loughlin & Swanson, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 25, 2011 to June 17, 2011	Procedure Codes 97110, G0283, 97012	$1,288.50	$1,043.02

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 medical fee guideline for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B20 – Srvc partially/fully furnished by another provider

- GP – Service delivered under OP PT care plan
- 196 – Non Network provider
- B5 – Pymnt Adj/Program guidelines not met or exceeded.
- 197 – Payment adjusted for absence of precert/preauth
- 168 – No additional allowance recommended
- 193 – Original payment decision maintained

Issues

1. Did the respondent support denial reason code B20 – "Srvc partially/fully furnished by another provider"?
2. Did the respondent support denial reason code 197 – "Payment adjusted for absence of precert/preauth"?
3. What is the recommended reimbursement for the disputed physical therapy services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with reason code B20 – "Srvc partially/fully furnished by another provider." The disputed services were performed by a licensed physical therapy assistant. Review of the submitted medical bills finds that the bills were signed by the supervising physical therapist, but not by the licensed physical therapy assistant that rendered the services.

   The respondent's position statement asserts that "Carrier denied reimbursement on the grounds that the services were furnished by another provider other than the one under whose name the bill was submitted" pursuant to 28 Texas Administrative Code §133.20(e)(2) which requires that a medical bill must be submitted "in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care."

   The requestor contends that the services were appropriately billed under Medicare policy in accordance with state laws. The requestor's position statement asserts, "According to the Medicare Part B therapy manual, Medicare does not recognize PTA's as providers therefore services can only be billed by the supervising LPT."

   However, the respondent argues that, because the rendering provider was a licensed physical therapist assistant, "Contrary to Division rule 133.20(e)(2), the services were not billed in her name. Therefore, reimbursement should not be recommended." The respondent cites as precedent a prior Division decision rendered in dispute number M4-08-6118-01 which held that "Although CMS does not allow physical therapy assistants, licensed or unlicensed, to bill for services rendered, per Division Rule at 28 TAC Section 134.202(a)(4), specific provisions contained in the Texas Workers' Compensation Act, or Texas Workers' Compensation Commission rules, including this rule, shall take precedence over any conflicting provision adopted by or utilized by CMS in administering the Medicare program."

   Regardless of the Division's holding in that dispute, the decision was overturned on hearing by the State Office of Administrative Hearings, SOAH Docket No. 454-09-5469.M4, which held that "Under TEX. LAB. CODE ANN. §401.011(22), 'health care provider' is defined as 'a health care facility or health care practitioner.' A review of the bills shows that they were provided by Injury One, although the physical therapy bills were signed by Ms. Henderson. Injury One is a health care facility as defined by TEX. LAB. CODE ANN. §401.011(20); therefore, the bills were submitted by the health care provider as required by the DWC rules."

   Pursuant to SOAH's holding in the above decision, review of the submitted documentation in this dispute finds that the requestor, KSF Orthopaedic Center, P.A., is a healthcare facility as defined by Texas Labor Code §401.011(22). Review of box 35 of the medical bill finds that the billing provider is listed as KSF Orthopaedic Center, P.A. Consequently, the Division concludes that the bills were submitted in the name of the health care provider in accordance with the requirements of §133.20(e)(2).

   The requestor submitted documentation to support by a preponderance of the evidence that the bills were submitted in accordance with Medicare payment policies as required by §134.203(b)(1) which requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply:

Medicare payment policies, including its coding; billing . . . and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. The respondent denied CPT code 97012 for dates of service June 7 and June 8, 2011 with reason code 197 – "Payment adjusted for absence of precert/preauth."

28 Texas Administrative Code §134.600(c) states that the insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:

(1) listed in subsection (p) or (q) of this section only when the following situations occur:
  (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
  (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;
  (C) concurrent utilization review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or
  (D) when ordered by the commissioner;
(2) or per subsection (r) of this section when voluntary certification was requested and payment agreed upon prior to providing the health care for any health care not listed in subsection (p) of this section.

28 Texas Administrative Code §133.2(3)(A) defines a medical emergency as:

the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:
  (i) placing the patient's health or bodily functions in serious jeopardy, or
  (ii) serious dysfunction of any body organ or part.

28 Texas Administrative Code §134.600(p)(5) states that non-emergency health care requiring preauthorization includes "physical and occupational therapy services."

No documentation was found to support a medical emergency as defined in §133.2. Nor did the requestor provide documentation to support preauthorization (or voluntary certification) pursuant to §133.600. This denial reason is supported. Consequently, reimbursement for CPT code 97012 for dates of service June 7 and June 8, 2011 is not recommended.

3. This dispute is regarding physical therapy services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that:

To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83 . . .
(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

The applicable Division conversion factor for calendar year 2011 is $54.54. Reimbursement is calculated as follows:

- Procedure code 97110, service date May 25, 2011, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.012 is 0.4554. The practice expense (PE) RVU of 0.41 multiplied by the PE GPCI of 0.992 is 0.40672. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.1305 is 0.011305. The sum of 0.873425 is multiplied by the Division conversion factor of $54.54 for a MAR of $47.64. Per Medicare policy, when more than one unit of designated therapy services is performed on the

same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $47.64. The PE reduced rate is $43.20 at 2 units is $86.40. The total is $134.04.

- Procedure code G0283, service date May 25, 2011, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.18 multiplied by the geographic practice cost index (GPCI) for work of 1.012 is 0.18216. The practice expense (PE) RVU of 0.18 multiplied by the PE GPCI of 0.992 is 0.17856. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.1305 is 0.011305. The sum of 0.372025 is multiplied by the Division conversion factor of $54.54 for a MAR of $20.29. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $18.34.
- Procedure code 97110, service date June 1, 2011, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.012 is 0.4554. The practice expense (PE) RVU of 0.41 multiplied by the PE GPCI of 0.992 is 0.40672. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.1305 is 0.011305. The sum of 0.873425 is multiplied by the Division conversion factor of $54.54 for a MAR of $47.64. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $47.64. The PE reduced rate is $43.20 at 2 units is $86.40. The total is $134.04.
- Procedure code G0283, service date June 1, 2011, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.18 multiplied by the geographic practice cost index (GPCI) for work of 1.012 is 0.18216. The practice expense (PE) RVU of 0.18 multiplied by the PE GPCI of 0.992 is 0.17856. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.1305 is 0.011305. The sum of 0.372025 is multiplied by the Division conversion factor of $54.54 for a MAR of $20.29. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $18.34.
- Procedure code 97110, service date June 3, 2011, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.012 is 0.4554. The practice expense (PE) RVU of 0.41 multiplied by the PE GPCI of 0.992 is 0.40672. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.1305 is 0.011305. The sum of 0.873425 is multiplied by the Division conversion factor of $54.54 for a MAR of $47.64. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $47.64. The PE reduced rate is $43.20 at 2 units is $86.40. The total is $134.04.
- Procedure code G0283, service date June 3, 2011, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.18 multiplied by

the geographic practice cost index (GPCI) for work of 1.012 is 0.18216. The practice expense (PE) RVU of 0.18 multiplied by the PE GPCI of 0.992 is 0.17856. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.1305 is 0.011305. The sum of 0.372025 is multiplied by the Division conversion factor of $54.54 for a MAR of $20.29. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $18.34.

- Procedure code 97110, service date June 7, 2011, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.012 is 0.4554. The practice expense (PE) RVU of 0.41 multiplied by the PE GPCI of 0.992 is 0.40672. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.1305 is 0.011305. The sum of 0.873425 is multiplied by the Division conversion factor of $54.54 for a MAR of $47.64. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $47.64. The PE reduced rate is $43.20 at 2 units is $86.40. The total is $134.04.
- Procedure code 97110, service date June 8, 2011, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.012 is 0.4554. The practice expense (PE) RVU of 0.41 multiplied by the PE GPCI of 0.992 is 0.40672. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.1305 is 0.011305. The sum of 0.873425 is multiplied by the Division conversion factor of $54.54 for a MAR of $47.64. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $47.64. The PE reduced rate is $43.20 at 2 units is $86.40. The total is $134.04.
- Procedure code 97110, service date June 10, 2011, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.012 is 0.4554. The practice expense (PE) RVU of 0.41 multiplied by the PE GPCI of 0.992 is 0.40672. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.1305 is 0.011305. The sum of 0.873425 is multiplied by the Division conversion factor of $54.54 for a MAR of $47.64. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $47.64.
- Procedure code 97110, service date June 16, 2011, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.012 is 0.4554. The practice expense (PE) RVU of 0.41 multiplied by the PE GPCI of 0.992 is 0.40672. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.1305 is 0.011305. The sum of 0.873425 is multiplied by the Division conversion factor of $54.54 for a MAR of $47.64. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $47.64. The PE reduced rate is $43.20 at 2 units is $86.40. The total is $134.04.

- Procedure code 97012, service date June 16, 2011, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.25 multiplied by the geographic practice cost index (GPCI) for work of 1.012 is 0.253. The practice expense (PE) RVU of 0.19 multiplied by the PE GPCI of 0.992 is 0.18848. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.1305 is 0.011305. The sum of 0.452785 is multiplied by the Division conversion factor of $54.54 for a MAR of $24.69. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $22.64.
- Procedure code 97110, service date June 17, 2011, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.012 is 0.4554. The practice expense (PE) RVU of 0.41 multiplied by the PE GPCI of 0.992 is 0.40672. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.1305 is 0.011305. The sum of 0.873425 is multiplied by the Division conversion factor of $54.54 for a MAR of $47.64. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $47.64. The PE reduced rate is $43.20. The total is $90.84.
- Procedure code 97012, service date June 17, 2011, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.25 multiplied by the geographic practice cost index (GPCI) for work of 1.012 is 0.253. The practice expense (PE) RVU of 0.19 multiplied by the PE GPCI of 0.992 is 0.18848. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.1305 is 0.011305. The sum of 0.452785 is multiplied by the Division conversion factor of $54.54 for a MAR of $24.69. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $22.64.

4. The total allowable reimbursement for the services in dispute is $1,043.02. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $1,043.02. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,043.02.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,043.02 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	October 22, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision***, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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