Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Heritage Hospital

Respondent Name
Wausau Underwriters Inc.

MFDR Tracking Number
M4-12-3530-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
August 1, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "[The injured employee] was evaluated at our physical therapy clinic on 2/8/12. She has had 48 treatment sessions through 7/10/12. We were notified by our billing department on 7/2/12 via letter that none of the physical therapy services are being covered due to the fact that we did not obtain authorization from the insurance adjuster through Liberty Mutual Insurance. The total amount billed was $27,999.00.

I have included a copy of the printout stating that through Liberty Mutual Workman's Compensation that the claim was open and billable (per Manuel) at the time of the evaluation, … During the course of her 48 treatment sessions, I was never contacted by an insurance adjustor or case worker asking for a status update or progress report for [the injured employee]. We did not receive a denial until 7/2/12 and at that time [the injured employee] had already had 46 treatment sessions. During the course of her therapy, [the injured employee] has followed up with her doctor and he has referred her back for continuing therapy of which all of the prescriptions are included in this packet …

Therefore, we are asking for retro-authorization for all of [the injured employee's] physical therapy sessions from 2/8/12 through 7/10/12. I believe this is entirely fair as the claim was open and billable from the beginning and that we had never received a denial before 7/2/12, and I was never contacted by an insurance adjustor or case worker regarding [the injured employee]. I have all of the signed progress notes from the doctor as well as additional documentation regarding [the injured employee's status]. [The injured employee] was in an auto-accident at work, she has progressed consistently throughout treatments, and she has benefited from the therapy services billed for."

Amount in Dispute: $27,999.00

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. The documentation submitted by the provider has again been reviewed in relation to the requirements of 134.60 of the Texas Rules.

Provider obtained preauthorization by UM for ten visits of Physical Therapy. Ten visits have been completed including dates of service 1/4/12, 1/11/12, 1/16/12, 1/18/12, 2/9/12, 2/13/12, 2/15/12, 2/17/12, 3/5/12, 3/8/12.

Dates of service in question are past 10th visit therefore not part of preauthorization and no additional payment will be made. I have attached copy of EOB's of the ten visits paid along with preauthorization rule, and also peer review that has been completed in regards to additional treatment."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 8, 2012 – July 10, 2012	Physical Therapy (97035, 97110, 97140, & 97001)	$27,999.00	$6.18

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §133.240 sets out the procedures for paying or denying medical bills.
3. 28 Texas Administrative Code §134.600 defines the services that require pre-authorization and how pre-authorization may be requested.
4. 28 Texas Administrative Code §134.203 sets out the fee guidelines for billing and reimbursing professional medical services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   For dates of service 2/8/12, 2/9/12, 2/13/12, 2/15/12, 2/17/12, 3/5/12, & 3/8/12:

   - 45 – not defined as required by 28 Texas Administrative Code §133.240
   - Z710 – The charge for this procedure exceeds the fee schedule allowance.
   - 150 – not defined as required by 28 Texas Administrative Code §133.240
   - Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered.

   For dates of service 2/20/12 – 2/22/12:

   - 39 – not defined as required by 28 Texas Administrative Code §133.240
   - X388 – Pre-authorization was requested but denied for this service per DWC Rule 134.600.
   - 150 – not defined as required by 28 Texas Administrative Code §133.240
   - Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered.

   For dates of service 2/24/12 – 3/27/12:

   - 197 – not defined as required by 28 Texas Administrative Code §133.240
   - X170 – Pre-authorization was required, but not requested for this service per DWC Rule 134.600.
   - 150 – not defined as required by 28 Texas Administrative Code §133.240
   - Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered.

   For dates of service 4/2/12 – 4/30/12:

   - 197 – not defined as required by 28 Texas Administrative Code §133.240
   - X170 – Pre-authorization was required, but not requested for this service per DWC Rule 134.600.
   - 150 – not defined as required by 28 Texas Administrative Code §133.240
   - Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered.
   - U301 – This item was reviewed on a previously submitted bill, or on this bill, with notification of decision issued to payor or provider (Duplicate billed).

   Explanations of benefits not found in the submitted documentation for dates of service after 4/3/12.

Issues

1. Was pre-authorization required for the disputed services?
2. Was pre-authorization obtained for the disputed services that required it?
3. What is the correct MAR for the payable services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute involves physical therapy charges that were, in part, denied for lack of pre-authorization. 28 Texas Administrative Code §134.600 (p) effective May 2, 2006, 31 TexReg 3566, states, "Non-emergency health care requiring preauthorization includes: … (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning."

   Review of the submitted documentation finds that all services in this dispute require pre-authorization, with the exception of the initial evaluation (CPT code 97001).

2. Review of the submitted documentation finds that the insurance carrier supports pre-authorization was received only for dates of service February 9, 2012, February 13, 2012, February 15, 2012, February 17, 2012, March 5, 2012, and March 8, 2012 found in this dispute. Documentation reviewed does not support that pre-authorization was obtained for other dates of service found in this dispute.

3. Procedure code 97001, service date February 8, 2012, 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 1.2 multiplied by the geographic practice cost index (GPCI) for work of 1.022 is 1.2264. The practice expense (PE) RVU of 0.91 multiplied by the PE GPCI of 1.023 is 0.93093. The malpractice RVU of 0.05 multiplied by the malpractice GPCI of 1.814 is 0.0907. The sum of 2.24803 is multiplied by the Division conversion factor of $54.86 for a MAR of $123.33. 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 subject to 25% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at **$123.33.**

   Procedure code 97110, service date February 9, 2012, 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 1.022 is 0.4599. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.023 is 0.45012. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.814 is 0.01814. The sum of 0.92816 is multiplied by the Division conversion factor of $54.86 for a MAR of $50.92. 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 subject to 25% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $50.92. The PE reduced rate is $44.75. The total is **$95.67**.

   Procedure code 97140, service date February 9, 2012, 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 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.022 is 0.43946. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 1.023 is 0.4092. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.814 is 0.01814. The sum of 0.8668 is multiplied by the Division conversion factor of $54.86 for a MAR of $47.55. 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 subject to 25% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is **$41.94**.

   Procedure code 97110, service date February 13, 2012, 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 1.022 is 0.4599. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.023 is 0.45012. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.814 is 0.01814. The sum of 0.92816 is multiplied by the Division conversion factor of $54.86 for a MAR of $50.92. 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 subject to 25% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at **$50.92.**

   Procedure code 97140, service date February 13, 2012, 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 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.022 is 0.43946. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 1.023 is 0.4092. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.814 is 0.01814. The sum of 0.8668 is multiplied by the Division conversion factor of $54.86 for a MAR of $47.55. 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 subject to 25% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $41.94 at 2 units is **$83.88**.

Procedure code 97110, service date February 15, 2012, 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 1.022 is 0.4599. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.023 is 0.45012. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.814 is 0.01814. The sum of 0.92816 is multiplied by the Division conversion factor of $54.86 for a MAR of $50.92. 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 subject to 25% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $50.92. The PE reduced rate is $44.75. The total is **$95.67**.

Procedure code 97140, service date February 15, 2012, 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 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.022 is 0.43946. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 1.023 is 0.4092. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.814 is 0.01814. The sum of 0.8668 is multiplied by the Division conversion factor of $54.86 for a MAR of $47.55. 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 subject to 25% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is **$41.94**.

Procedure code 97110, service date February 17, 2012, 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 1.022 is 0.4599. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.023 is 0.45012. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.814 is 0.01814. The sum of 0.92816 is multiplied by the Division conversion factor of $54.86 for a MAR of $50.92. 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 subject to 25% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $50.92. The PE reduced rate is $44.75. The total is **$95.67**.

Procedure code 97140, service date February 17, 2012, 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 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.022 is 0.43946. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 1.023 is 0.4092. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.814 is 0.01814. The sum of 0.8668 is multiplied by the Division conversion factor of $54.86 for a MAR of $47.55. 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 subject to 25% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is **$41.94**.

Procedure code 97110, service date March 5, 2012, 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 1.022 is 0.4599. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.023 is 0.45012. The malpractice RVU of 0.01 multiplied by the malpractice

GPCI of 1.814 is 0.01814. The sum of 0.92816 is multiplied by the Division conversion factor of $54.86 for a MAR of $50.92. 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 subject to 25% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at **$50.92**.

Procedure code 97140, service date March 5, 2012, 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 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.022 is 0.43946. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 1.023 is 0.4092. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.814 is 0.01814. The sum of 0.8668 is multiplied by the Division conversion factor of $54.86 for a MAR of $47.55. 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 subject to 25% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $41.94 at 2 units is **$83.88**.

Procedure code 97110, service date March 8, 2012, 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 1.022 is 0.4599. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.023 is 0.45012. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.814 is 0.01814. The sum of 0.92816 is multiplied by the Division conversion factor of $54.86 for a MAR of $50.92. 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 subject to 25% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at **$50.92**.

Procedure code 97140, service date March 8, 2012, 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 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.022 is 0.43946. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 1.023 is 0.4092. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.814 is 0.01814. The sum of 0.8668 is multiplied by the Division conversion factor of $54.86 for a MAR of $47.55. 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 subject to 25% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $41.94 at 2 units is **$83.88**.

4. The total allowable for the services in dispute is $940.56. Review of the submitted documentation finds that the insurance carrier paid $934.38. Therefore, an additional reimbursement of $6.18 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 $6.18.

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 $6.18 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	March 30, 2015
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 28 Texas Administrative Code §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 the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

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