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
Pain and Recovery Clinic

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-16-0510-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
October 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We rendered services that were preauthorized by the carriers third party administrator and feel that our facility should be paid according to the fee schedule guidelines."

Amount in Dispute: $206.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office found that the requestor had received preauthorization of CPT codes 97110, 97140, and 97112 on 6/4/2015, however the Office was unable to locate the health care provider's request in their dispute packet to determine if the requestor had received preauthorization for time in excess of the ODG's and Medicare's guidelines of 45-60 minutes."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 27, 2015	Physical Therapy (97110, 97140, G0283)	$206.22	$112.22

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 §134.600 sets out the procedures for preauthorization of medical services.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 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.

- 168 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services
- 197 – Payment denied/reduced for absence of precertification/authorization.
- 15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.
- 293 – This procedure requires prior authorization and none was identified.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Do the disputed services require preauthorization?
2. Were the disputed services preauthorized?
3. Are the insurance carrier's reasons for reduction of payment supported for CPT code 97110?
4. Are the insurance carrier's reasons for denial of payment supported for CPT code 97140?
5. Are the insurance carrier's reasons for denial of payment supported for CPT code G0283?
6. What is the maximum allowable reimbursement (MAR) for the disputed services?
7. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute involves the following CPT codes:

    - 97110-GP – Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
    - 97140-GP – Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
    - G0283 – Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

    28 Texas Administrative Code §134.600(p) states, in relevant part:

    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;
    (iii) Orthotics/Prosthetics Management;
    (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and
    (B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;
    (C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:
    (i) the date of injury; or
    (ii) a surgical intervention previously preauthorized by the insurance carrier;

    The Division finds that the disputed services were not rendered within the first two weeks immediately following the date of injury. Submitted documentation does not support that the disputed services were rendered within the first two weeks immediately following a surgical intervention. Therefore, the disputed services require preauthorization in accordance with 28 Texas Administrative Code §134.600.

2. 28 Texas Administrative Code §134.600(l) states in relevant part:

    … The approval shall include:

(1) the specific health care;
(2) the approved number of health care treatments and specific period of time to complete the treatments;
(3) a notice of any unresolved dispute regarding the denial of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury; and
(4) the insurance carrier's preauthorization approval number that conforms to the standards described in §19.2009(a)(4) of this title…

Review of the submitted documentation finds a Preauthorization Determination Letter dated June 4, 2015 that approved CPT codes 97110, 97112, and 97140 for 12 sessions with dates of service June 4, 2015 through July 24, 2015, under approval number 77724. The Division finds that disputed CPT codes 97110 and 97140 were preauthorized in accordance with 28 Texas Administrative Code §134.600. The Division finds that documentation does not support that disputed CPT code G0283 was preauthorized in accordance with 28 Texas Administrative Code §134.600.

3. The insurance carrier reduced disputed CPT code 97110 with claim adjustment reason codes 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," and 168 – "BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES."

   Review of the submitted information does not support that this service does not exceed the preauthorized 12 sessions for this CPT code. The documentation does not support that the approval included a discussion to limit the number of units being authorized. For this reason, the insurance carrier's denial reason is not supported for CPT 97110. The disputed service will therefore be reviewed per applicable Division rules and fee guidelines.

4. The insurance carrier reduced disputed CPT code 97140 with claim adjustment reason codes 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," and 168 – "BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES."

   Review of the submitted information does not support that this service does not exceed the preauthorized 12 sessions for this CPT code. The documentation does not support that the approval included a discussion to limit the number of units being authorized. For this reason, the insurance carrier's denial reason is not supported for CPT 97110. The disputed service will therefore be reviewed per applicable Division rules and fee guidelines.

5. The insurance carrier denied disputed CPT code G0283 with claim adjustment reason codes 197 – "PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION," and 293 – "THIS PROCEDURE REQUIRES PRIOR AUTHORIZATION AND NONE WAS IDENTIFIED." Because preauthorization was required and submitted documentation does not support that this procedure was preauthorized, the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended for this service.

6. 28 Texas Administrative Code §134.203 (c) states,

   To determine the MAR 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 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. The Division conversion factor for 2015 is $56.20.

For CPT code 97110 on June 27, 2015, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.458550. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.006 is 0.442640. 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 50% of the practice expense. This procedure does not have the highest PE for this date. The reduced PE is 0.221320. The malpractice (MP) RVU of 0.02 multiplied by the MP GPCI of 0.955 is 0.019100. The sum of 0.698970 is multiplied by the Division conversion factor of $56.20 for a total of $39.28. The total MAR for 4 units is $157.12.

For CPT code 97140 on June 27, 2015, the RVU for work of 0.43 multiplied by the GPCI for work of 1.019 is 0.438170. The PE RVU of 0.40 multiplied by the PE GPCI of 1.006 is 0.402400. 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 PE. Payment for each subsequent unit is reduced by 50% of the PE. This procedure does not have the highest PE for this date. The reduced PE is 0.201200. The MP RVU of 0.01 multiplied by the MP GPCI of 0.955 is 0.009550. The sum of 0.648920 is multiplied by the Division conversion factor of $56.20 for a total of $36.47. The total MAR for 2 units is $72.94.

7. The total MAR for the disputed services is $230.06. The insurance carrier paid $117.84. An additional reimbursement of $112.22 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 $112.22.

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 $112.22 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	November 20, 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, 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 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 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.