



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION
GENERAL INFORMATION

Requestor Name

HUMPAL PHYSICAL THERAPY

MFDR Tracking Number

M4-17-0552-01

MFDR Date Received

October 27, 2016

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative

Box Number 45

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have provided the insurance carrier with all needed information to substantiate the medical necessity of this patient rehab program in excess of 60 minutes. We respectfully ask for your assistance in helping us to receive payment according to Texas Worker's Compensation guidelines which do NOT cap Physical [sic] therapy services at 60 minutes."

Amount in Dispute: \$472.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office found that the requestor had received preauthorization of CPT codes 97110, 97140 and 97112 x 9 sessions on 1/22/2016, however the Office was unable to locate evidence in the health care provider's dispute request 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

Table with 4 columns: Date(s) of Service, Disputed Service(s), Amount In Dispute, Amount Due. Row 1: January 27, 2016, January 28, 2016 and January 29, 2016; 97110; \$472.50; \$208.50

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 §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 119 – Benefit maximum for this time period or occurrence has been reached.
 - 168 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services.
 - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
 - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on the re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Is the carrier’s denial reason supported?
2. Did the requestor obtain preauthorization for the disputed services?
3. What are CMS payment policies?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 97110 rendered on January 27, 2016, January 28, 2016 and January 29, 2016. The insurance carrier denied/reduced the disputed charges with denial reason codes “119 – Benefit maximum for this time period or occurrence has been reached” and “168 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services.”

The insurance carrier states, “It is not noted in the preauthorization letter that additional units beyond the 4 units were being authorized pursuant to the ODG as it states additional units should be reviewed for medical necessity and authorized if determined to be medically appropriate to the individual worker.”

The requestor states, “We respectfully ask for your assistance in helping us to receive payment according to Texas Worker’s Compensation guidelines which do NOT cap Physical [sic] therapy services at 60 minutes.”

The insurance carrier submitted insufficient documentation to support that the disputed services were limited to 4 units as indicated in the position statement and the EOB. The Division concludes that the respondent’s denial reason is not supported and will further explain in paragraph #2 below. The disputed service(s) are therefore reviewed per applicable Division rules and fee guideline.

2. 28 Texas Administrative Code §134.600(p) (5) states in pertinent part, “(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...”

The respondent submitted a copy of a preauthorization letter dated January 22, 2016, the preauthorization letter authorized the following:

Requested Services:

CPT	Description	Request Date	Determination Date	Status	Authorization #	Dates of Service
97110	Therapeutic Exercise	01/19/2016	01/22/2016	Preauthorized	85013	01/22/16 to 02/21/16
97112	Neuromuscular Re-education	01/19/2016	01/22/2016	Preauthorized	85013	01/22/16 to 02/21/16
97140	Manual Therapy Techniques, ea. 15 min	01/19/2016	01/22/2016	Preauthorized	85013	01/22/16 to 02/21/16

The preauthorization letter further states: “Determination Note: IMO has preauthorized medical necessity for 9 sessions of Physical Therapy, Lower Right Extremity to be done on an Outpatient basis.”

The preauthorization letter identifies the “Requested Services” (indicated in the above table). The “Requested Services” does not contain a number of units identified by the requestor. The insurance carrier preauthorized the requested services as indicated in the “Determination Note.” No documentation was submitted to support that a peer to peer review was conducted to modify/change the requested services and or limit the number of units to 4. The Division finds that the insurance carrier’s denial reason is not supported and as a result, the disputed services are reviewed pursuant to the applicable rules and guidelines.

28 Texas Administrative Code §134.600(c) (1) (B) states in pertinent part, “(c) 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... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care...”

3. 28 Texas Administrative Code §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The requestor billed CPT Codes 97112 and 97110 for each disputed date of service, January 27, 2016, January 28, 2016 and 97112, 97110 and 97002 on January 29, 2016. Per CMS many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying an MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings. The Division will therefore determine reimbursement based on CMS's MPPR policy.

4. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) 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. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (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..."

Procedure code 97110, service date January 27, 2016, 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 is 0.45. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.92 is 0.4048. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.822 is 0.01644. The sum of 0.87124 is multiplied by the Division conversion factor of \$56.82 for a MAR of \$49.50. 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 PE reduced rate is \$38.00 at 4 units is \$152.00. The insurance carrier issued a payment in the amount of \$99.00, as a result, the requestor is entitled to an additional payment of \$53.00.

Procedure code 97110, service date January 28, 2016, 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 is 0.45. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.92 is 0.4048. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.822 is 0.01644. The sum of 0.87124 is multiplied by the Division conversion factor of \$56.82 for a MAR of \$49.50. 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 PE reduced rate is \$38.00 at 4 units is \$152.00. The insurance carrier issued a payment in the amount of \$99.00, as a result, the requestor is entitled to an additional payment of \$53.00.

Procedure code 97110, service date January 29, 2016, 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 is 0.45. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.92 is 0.4048. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.822 is 0.01644. The sum of 0.87124 is multiplied by the Division conversion factor of \$56.82 for a MAR of \$49.50. 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 PE reduced rate is \$38.00 at 4 units is \$152.00. The insurance carrier issued a payment in the amount of \$49.50, as a result, the requestor is entitled to an additional payment of \$102.50.

5. Review of the submitted documentation finds that the requestor is entitled to an additional payment in the amount of \$208.50. Therefore, 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 \$208.50.

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 \$208.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

December 16, 2016
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 prefriere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.