



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

Patient Care Injury Clinic PA

Respondent Name

American Interstate Insurance

MFDR Tracking Number

M4-17-2293-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

March 30, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After requesting reconsideration in a timely fashion VIA mail to the Amerisafe insurance` it is quite evident that the carrier is unwilling to reimburse our facility for services rendered and that were preauthorized. We submitted our bills and clinical documentation in a timely fashion. We feel that our facility should be paid according to the workers compensation fee schedule guidelines."

Amount in Dispute: \$450.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based upon the submitted information we do not believe any additional recommendation for payment is warranted at this time."

Response Submitted by: Medata Inc. on behalf of American Interstate Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 13 – 21, 2017	Physical Therapy Services	\$450.12	\$311.98

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 reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out the requirements for preauthorization and concurrent

utilization review.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - RC &1 – The number of visits exceeds the CAA Automate Approval number defined within the Official Disability Guidelines (ODG) for the conditions for which the patient is being treated as identified by the ICD code (s). Please provide an explanation of the medical necessity of this services
 - RC MZ – The usual treatment session provided in the home or office setting is 30 to 45 minutes. The medical necessity of services for an unusual length of time must be documented
 - RC NG – Since procedure code 97140 includes several modalities, all with different indications, documentation of the diagnosis or condition of the patient and a description of the services rendered must be submitted
 - P12 – Workers compensation jurisdictional fee schedule adjustment
 - P13 – Payment reduce or denied based on workers’ compensation regular or payment policies use only if no other code is applicable

Issues

1. Is the carrier’s denial supported?
2. What is the applicable rule that applies to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for professional medical services,
 - CPT Code 97112, GP, Date of service February 13, 2017
 - CPT Code 97110, GP, Date of service, February 13, 2017
 - CPT Code 97140, GP, Date of service, February 13, 2017
 - CPT Code 97140, GP, Date of service, February 15, 2017
 - CPT Code 97110, GP, Date of service, February 21, 2017

The requestor states in pertinent part ...”services rendered and that were preauthorized.”

Review of the submitted documentation found prior authorization number “0002-2327-9600” listed in box 23 of medical claim and a document dated January 20, 2017 which states,

Services Requested – “Postsurgical active physical rehabilitation to the lumbar spine 3 times a week for 4 weeks, 97110, 97112, 97140”

Services Approved From: 1/20/2017 – 3/3/2017

28 Texas Administrative Code 134.600 (c) (5) states,

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;

(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;

Based on the evidence submitted with this dispute, the Division finds the services were prior authorized and no limitations on the number of units was placed on the authorized codes 97110, 97112 and 97140.

Therefore, the requestor's position is supported and the applicable fee guideline will be calculated per Division rules and fee guidelines.

2. The insurance carrier denied disputed services as,

RC &1 – “Disability Guidelines (ODG) for the conditions for which the patient is being treated as identified by the ICD code (s). Please provide an explanation of the medical necessity of this services”

RC MZ – “The usual treatment session provided in the home or office setting is 30 to 45 minutes. The medical necessity of services for an unusual length of time must be documented”

RC NG – “Since procedure code 97140 includes several modalities, all with different indications, documentation of the diagnosis or condition of the patient and a description of the services rendered must be submitted”

As stated above the insurance carrier is liable for services associated with the prior authorized services. As no limits were placed on the approved codes, no limits will be applied to the number of units allowed per day. Further, the carrier authorized code 97140 without any description of services. The carrier's denials for “description of the services rendered must be submitted” is not supported. The services in dispute will be reviewed per applicable fee guidelines.

3. 28 Texas Administrative Code 134.203 (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 date of service yearly conversion factor.

- Procedure code 97110, service date February 13, 2017 has a MAR of \$52.29. 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 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$39.72 at 4 units is \$158.88.
- Procedure code 97140, service date February 13, 2017 has a MAR of \$48.30. 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 \$36.87 at 2 units is \$73.74.
- Procedure code 97112, service date February 13, 2017 has a MAR of \$54.58. 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 has the highest PE for this date. The first unit is paid at \$54.58.
- Procedure code 97140, service date February 15, 2017 has a MAR of \$48.30. 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 has the highest PE for this date. The first unit is paid at \$48.30. The PE reduced rate is \$36.87. The total is \$85.17.

- Procedure code 97110, service date February 21, 2017 has a MAR of \$52.29. 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 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at \$52.29. The PE reduced rate is \$39.72 at 3 units is \$119.16. The total is \$171.45.

4. The total allowable reimbursement for the services in dispute is \$543.82. This amount less the amount previously paid by the insurance carrier of \$231.84 leaves an amount due to the requestor of \$311.98. 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 \$311.98.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$311.98, 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	Date

May 11, 2017

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.