



**Texas Department of Insurance**

**Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645  
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**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

ERIC A VANDERWERFF, DC

**Respondent Name**

TRUMBULL INSURANCE CO

**MFDR Tracking Number**

M4-17-3016-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

JUNE 13, 2017

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "To further underscore the scam, I would also like to inform you that we include a copy of the carrier's very own PRE-AUTHORIZATION **LETTER** with every bill we send. Yet, the carrier pretends like they never saw the letter, never saw the prior authorization number in Box 23.....but they do NOT pretend NOT to pay us. No, no, no."

**Amount in Dispute:** \$579.20

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "the provider received certification for 6 sessions of OT for the left knee. The provider billed for and was reimbursed for the following dates of service: 06/29/16, 06/30/16, 07/06/16, 07/07/16, 07/13/16, 07/14/16, 07/18/16, 07/21/16, for a total of 8 sessions. Review of the disputed dates of service (06/29/16, 06/30/16, 07/14/16, 07/18/16 & 07/21/16) shows that the medical documentation submitted with the billing does not support the units billed."

**Response Submitted by:** The Hartford

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 29, 2016 June 30, 2016 July 14, 2016 July 18, 2016 July 21, 2016	CPT Code 97140-59-GP (X2)	\$49.20 \$49.20 \$98.40 \$98.40	\$122.28
July 13, 2016 July 14, 2016 July 18, 2016 July 21, 2016	CPT Code 97116-59-GP	\$46.40/ per day	\$69.52
TOTAL		\$579.20	\$191.80

**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 §134.203 effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, effective July 1, 2012, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
5. 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.
  - W3-Additional payment made on appeal/reconsideration.
  - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
  - 1115-We find the original review to be accurate and are unable to recommend any additional allowance..

## **Issues**

1. What is the applicable rule for determining reimbursement of the disputed services?
2. Does a preauthorization issue exist?
3. What is the recommended payment for the services in dispute? Is the requestor entitled to additional reimbursement?

## **Findings**

1. The fee guideline for Professional Care services is found in 28 Texas Administrative Code §134.203.

According to the explanation of benefits, the respondent denied reimbursement for the disputed physical therapy services based upon “119- Benefit maximum for this time period or occurrence has been reached” and Per 28 Texas Administrative Code §134.600(p)(5)(A) the non-emergency healthcare that requires 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.”

The June 17, 2016 report supports preauthorization was obtained for 6 sessions of CPT codes 97140, 97110, G0283, 97112, 97116.

The respondent contends “The provider billed for and was reimbursed for the following dates of service: 06/29/16, 06/30/16, 07/06/16, 07/07/16, 07/13/16, 07/14/16, 07/18/16, 07/21/16, for a total of 8 sessions.” Because preauthorization was obtained for six (6) sessions, a preauthorization issue exists for dates of service July 18 and 21, 2016.

2. The respondent also denied reimbursement for the disputed physical therapy services based upon “168-Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services”.

28 Texas Administrative Code §134.203(a)(5) states “Medicare payment policies” when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.”

28 Texas Administrative Code §134.203(b) states “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...”

28 Texas Administrative Code §134.203(a)(7) states “Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program. Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review

Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.”

The respondent is basing the denial of payment for the disputed physical therapy services on Medicare policies that limit the number of units/sessions of physical therapy allowed per claim. Per 28 Texas Administrative Code §134.203(a)(7) when there is a conflict between Medicare policies and the division rules, the division rules take precedence. Because the requestor obtained preauthorization for the disputed services, this takes precedence over the limits set out in Medicare policies. The division finds that the requestor obtained preauthorization for the disputed services rendered from Jun 29, 2016 though July 14, 2016 and reimbursement is due.

3. Per 28 Texas Administrative Code §134.203(c)(1)(2), “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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007.”

CMS published Medical Learning Network (MLN) Matters, effective January 1, 2011 which states in part “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 a 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 multiple procedure rule discounting applies to the disputed service.

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2016 DWC conversion factor for this service is 56.82.

The Medicare Conversion Factor is 35.8043

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75061, which is located in Irving, Texas; therefore, the Medicare participating amount is based on locality “Dallas, Texas”.

Using the above formula and multiple procedure discounting rule the Division finds the following:

Code	No. of Units	Medicare Participating Amount	MAR	MAR X No. of Units X MPD	MAR X No. of Units X DOS	IC Paid	Amount Due
97140-59-GP	2	\$30.40	\$48.24	\$73.56	\$73.56 X3 = \$220.68	\$98.40	\$122.28
97116-59-GP	1	\$28.95	\$45.93	\$34.76	\$34.76 X 2 = \$69.52	\$0.00	\$69.52

**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 \$191.80.

**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 \$191.80, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Signature	Medical Fee Dispute Resolution Officer	7/26/2017 Date
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***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.**