



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

Elite Healthcare Fort Worth

Respondent Name

Ace American Insurance Co

MFDR Tracking Number

M4-15-2902-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

May 7, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier did pay the correct price for office visits, with that being said carrier should have paid correct prices for therapy."

Amount in Dispute: \$11.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have reprocessed the bill and payment has been made."

Response Submitted by: Broadspire, P.O. Box 14351, Lexington, KY 40512-4351

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 21, 2015	97112	\$11.06	\$0.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 790 – This charge was reimbursed in accordance to the Texas Medical fee guideline
 - P12 – Workers compensation jurisdictional fee schedule adjustment
 - 18 – Exact duplicate claim/service
 - A19 – Upon further review, additional payment is warranted
 - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 790 – "This charge was reimbursed in accordance to the Texas Medical fee guideline" and P12 – "Workers compensation jurisdictional fee schedule adjustment." 28 Texas Administrative Code §134.203 (b) requires that,

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."

Review of the submitted information finds that these services are outpatient physical therapy. The Center for Medicare and Medicaid Services publication found at, <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8206.pdf> to states,

MLN Matters® Number: MM8206, "Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to the PE 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. Effective for claims with dates of service on or after April 1, 2013, full payment is made for work and malpractice and 50 percent payment is made for the PE for subsequent units and procedures, furnished to the same patient on the same day."

Therefore even though only 97112 is found on the submitted DWC-60 pursuant to Rule 134.203(b) all the services will be calculated per applicable fee guidelines to properly apply the Multiple Procedure Discount described above.

2. 28 Texas Administrative Code §134.203 (c) states in pertinent part,

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 (yearly conversion factor).

The service in dispute was one of three services performed on the same date of service. To apply Medicare payment policies for physical therapy services, the following calculation was done.

Procedure code 97140, service date January 21, 2015. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.005 is 0.43215. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 0.995 is 0.398. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 0.83787 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$47.09. 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 \$35.90 at 2 units is \$71.80.

Procedure code 97112, service date January 21, 2015). For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.005 is 0.45225. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 0.995 is 0.4776. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 0.93757 is multiplied by the Division

conversion factor of \$56.20 for a MAR of \$52.69. 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 \$39.27 at 2 units is \$78.54.

Procedure code 97113, service date January 21, 2015. For this procedure, the relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1.005 is 0.4422. The practice expense (PE) RVU of 0.76 multiplied by the PE GPCI of 0.995 is 0.7562. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.00772. The sum of 1.20612 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$67.78. 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 \$67.78. The PE reduced rate is \$46.53 at 3 units is \$139.59. The total is \$207.37.

- 3. The total allowable reimbursement for the date of service that contained the service in dispute is \$357.71. This amount less the amount previously paid by the insurance carrier of \$470.06 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

The carrier made a supplemental payment after the request for MFDR was made however; the requestor chose not to withdraw the MFDR request.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

August , 2015
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.