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 South Dallas

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-18-3385-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 15, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above date of service was not paid in full and has been returned due to reason: "Workers' compensation jurisdictional fee schedule adjustment."

July 5, 2018 – "They partially paid. They still owe $75.25 for each date of service."

Amount in Dispute: $302.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 7 - 12, 2017	Physical Therapy	$302.38	$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

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 59 – Processed based on multiple or concurrent procedure rules
   - 112 – Service not furnished directly to the patient and/or not documented
   - 193 – Original payment decision is being maintained

Issues

1. Is the carrier's reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for date of service September 7, 2017 Code 97110 and 97140 and September 12, 2017 Codes 97110 and 97140. The carrier reduced the allowed amount as P12 – "Workers' compensation jurisdictional fee schedule amount" and 59 – "Processed based on multiple or concurrent procedure rules."

   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.

   On April 1st of 2013, Medicare implemented the Medicare Multiple Procedure Payment Reduction (MPPR). The MPPR policy may be found in the CMS Claims Processing Manual 100-04, Chapter 5, section 10.7 found at www.cms.gov. The MPPR policy applies therefore the carrier's reduction does apply and was used in the calculation of the maximum allowable reimbursement shown below.

   The MAR is calculated by the DWC Conversion Factor/Medicare Conversion Factor multiplied by the Medicare allowable. To appropriately apply the MPPR policy all services performed for each date of service is calculated below:

   - Procedure code 97110 billed September 7, 2017 for four units has a PE of 0.45 not the highest for this date and will be paid at the reduced rate of $25.12. 57.5/35.887 x $25.12 x 4 = $160.99
   - Procedure code 97112 billed September 7, 2017 for two units has a PE of 0.49 the highest for this date. The first unit will be paid at the full rate of $34.74. The second unit will be paid at $25.84. 57.5/35.8887 x $34.74 = $55.66. 57.5/35.8887 x $25.84 = $41.40. $55.66 + 41.40 = $96.96
   - Procedure code 97140 billed September 7, 2017 for 2 units has a PE of 0.41 not the highest for this date and will be paid at the reduced rate of $23.51. 57.5/35.8887 x $23.51 x 2 = $81.74
   - Procedure code 97110 billed September 12, 2017 for four units has a PE of 0.45 not the highest for this date and will be paid at the reduced rate of $25.12. 57.5/35.887 x $25.12 x 4 = $160.99
   - Procedure code 97112 billed September 12, 2017 for two units has a PE of 0.49 the highest for this date. The first unit will be paid at the full rate of $34.74. The second unit will be paid at $25.84. 57.5/35.8887 x $34.74 = $55.66. 57.5/35.8887 x $25.84 = $41.40. $55.66 + 41.40 = $96.96
   - Procedure code 97140 billed September 12, 2017 for 2 units has a PE of 0.41 not the highest for this date and will be paid at the reduced rate of $23.51. 57.5/35.8887 x $23.51 x 2 = $81.74

The total allowable reimbursement for the services in dispute is $679.38. The carrier paid $694.46. No additional payment is recommended.

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to no additional reimbursement for the services in dispute.

Authorized Signature

		November 2, 2018
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 Rule §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 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. **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.