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
Old Republic Insurance Co

MFDR Tracking Number
M4-18-3457-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
May 18, 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."

Amount in Dispute: $271.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…based upon additional reimbursement under CPT code 97110 of $120.73 and under CPT code 97140 of $74.94. The provider is not entitled to any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 22, 2017	97110, 97140	$271.92	$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
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 59 – Processed based on multiple or concurrent procedure rules

- B12 – Services not documented in patients' medical records

Issues

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

Findings

1. The requestor is seeking additional reimbursement of $271.92 for physical therapy services rendered on August 22, 2017. The insurance carrier reduced the disputed services with claim adjustment reason code P12 – "Workers compensation jurisdictional fee schedule adjustment and 59 – "Processed based on multiple or concurrent procedure rules." The denial B12 – "Services not documented in patient's medical record" was not maintained upon reconsideration.

   28 Texas Administrative Code §134.203 sets out the medical fee guideline for professional services and contains the following applicable rules.

   > (a)(5) "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.
   >
   > (b) 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."

   The Medicare payment policy is found in the Medicare Claims Processing Manual, Chapter 5, Section, 10.7 which states in pertinent part,

   > *Medicare applies an MPPR 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.*
   >
   > *For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 50 percent payment is made for the PE for services submitted on either professional or institutional claims.*
   >
   > *To determine which services will receive the MPPR, contractors shall rank services according to the applicable PE relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services.*

   Based on the above, the carriers reduction based on "multiple or concurrent procedure rule" is supported. The calculation of the fee schedule amount is shown below.

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 (date of service yearly conversion factor)

   The maximum allowable reimbursement in calculated as follows:

   - Procedure code 97110, billed August 22, 2017, four units has a PE of 0.45, not the highest for this date and will be paid at the reduced allowable of $25.12. The MAR calculation is Workers Compensation

Factor/Medicare Conversion Factor x Medicare allowable or 57.5/35.8887 x $25.12 x 4 = $160.99. The carrier paid $160.97 on June 18, 2018. No additional payment is recommended.

- Procedure code 97140, billed August 22, 2017, two units has a PE of 0.41, not the highest for this date and will be paid at the reduced allowable of $23.39. 57.5/35.8887 x $23.39 x 2 = $74.95. The carrier paid $74.94 on June 18, 2018. 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 $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		August 10, 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.