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
ARCH INSURANCE COMPANY

MFDR Tracking Number
M4-19-0274-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 18, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Elite healthcare submitted all proper documentation to support every CPT code billed for the above date of service…"

Amount in Dispute: $140.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "we have escalated the bill in question for bill review audit to manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 30, 2018	Physical Therapy Services: 97110, 97140	$140.34	$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 fee guideline 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.
   - W3 – Additional payment made on appeal/reconsideration.
   - 112 – Service not furnished directly to the patient and/or not documented.
   - MRCA - This service was reduced in accordance with the Workers' Compensation Fee Schedule rules for Physician Services.
   - P300 – The amount paid reflects a fee schedule reduction.
   - Z710 - The charge for this procedure exceeds the fee schedule allowance.
   - 18 – Exact duplicate claim/service.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied procedure code 97140 with claim adjustment reason code:
   - 112 – Service not furnished directly to the patient and/or not documented.

   28 Texas Administrative Code §134.203(b)(1) requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply "Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers . . . 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 therapist note and flow sheet found insufficient information to support CPT code 97140, defined as "manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes." The therapist note states, "massage therapy performed," which should be reported under code 97124 (massage therapy), not 97140. The flow sheets document 57 minutes for therapeutic exercises (97110) and 29 minutes for neuromuscular reeducation (97112), but no documentation was found to support manual therapy, mobilization, manipulation, manual lymphatic drainage, manual traction, or any similar service.

   Further, code 97140 is a *timed* code. No documentation was found of the duration or of start and stop times for any components of this service. The medical records do not support the service as billed. Consequently, the carrier's denial reason is supported. Additional reimbursement cannot be recommended for code 97140.

2. This dispute regards physical therapy services with reimbursement subject to the *Medical Fee Guideline for Professional Services*, 28 Texas Administrative Code §134.203, requiring the maximum allowable reimbursement (MAR) be determined by Medicare payment policies modified by DWC rules. The MAR is the sum of geographically adjusted work, practice expense and malpractice values multiplied by the DWC annual conversion factor.

   When more than one unit is billed of therapy services designated by multiple-procedure payment indicator '5', Medicare policy requires the first unit of therapy with the highest practice expense for that day be paid in full. Payment is reduced by 50% of the practice expense (PE) for each extra therapy unit provided on that date.

   Reimbursement is calculated as follows:

   - Procedure code 97110, has a Work RVU of 0.45 multiplied by the Work GPCI of 1.012 is 0.4554. The practice expense RVU of 0.4 multiplied by the PE GPCI of 1.014 is 0.4056. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.768 is 0.01536. The sum is 0.87636 multiplied by the DWC conversion factor of $58.31 for a MAR of $51.10. For each extra therapy unit after the first unit of the code with the highest PE, payment is reduced by 50% of the practice expense. The PE for this code is not the highest. The PE reduced rate is $39.28 at 4 units is $157.12.

   The total allowable reimbursement for the services in dispute is $157.12. The insurance carrier paid $157.10. No additional payment is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

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

	Grayson Richardson	November 30, 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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.