TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare Garland, Inc

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-19-3639-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
March 29, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…these claims should be paid in full…"

Amount in Dispute: $57.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company has determined no further payment is due."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 2, 2019	97140 GP	$57.73	$35.63

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 charges.
3. 28 Texas Administrative Code §134.203 sets out the guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - P300 – The amount paid reflects a fee schedule reduction
   - Z710 – The charge for this procedure exceeds the fee schedule allowance

Issues

1. Is additional reimbursement due to the requestor?

Findings

1. The requestor is seeking $57.73 for physical therapy services rendered January 2, 2019. The requestor is seeking additional reimbursement in the amount of $234.88 for physical therapy services rendered on October 12, 2017. The insurance carrier reduced the disputed service based on the workers' compensation fee schedule. 28 TAC 134.203 (c) (1) 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).

28 TAC 134.203 (b) shown below requires the application of the Multiple Procedure Payment Reduction Rate. Code 97140 has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of $22.33. 58.31/35.9996 x $22.33 x 2 = $72.34.

The respondent states in their position statement, Per Clinical Validation review, no additional allowance is due. CPT code 97140 is billed when the provider performs a manual therapy technique on one or more regions. This code is billed in 15 minute increments. The actual time spend with the patient must be documented to support the multiple units billed. This time has not been supplied by the provider for this procedure, therefore we will uphold this down code."

28 TAC 134.203 (b) (1) 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;

The Medicare Claims Processing Manual, Chapter 5, at www.cms.gov states, "If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes, through and including 37 minutes, then 2 units should be billed." Review of the physical therapy notes find, "PNF stretches = 15 and Vibration Plate = 10 for a total of 25. Per the Medicare payment policy two units should have been billed. The respondents statement is not supported.

The total allowed amount is $72.34. The insurance carrier paid $36.71. The remaining balance of $35.63 is due to the requestor.

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 $35.63

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $35.63159.26, plus applicable accrued interest per 28 Texas Administrative Code §134.130due within 30 days of receipt of this order.

Authorized Signature

		April 30, 2019
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.