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 FT. WORTH

Respondent Name
XL INSURANCE AMERICA INC

MFDR Tracking Number
M4-19-4141-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 15, 2019

Response Submitted By
Gallagher Bassett

REQUESTOR'S POSITION SUMMARY

"PLEASE SEE ATTACHED DOCUMENTATION REGARDING MPPR. CARRIER IS TO PAY 80% PAYMENT FOR SERVICES FURNISHED. CARRIER ONLY PAID 75% ON THIS DATE OF SERVICE."

RESPONDENT'S POSITION SUMMARY

"CPT code 97140 is billed when the provider performs a manual therapy technique… This code is billed in 15 minute increments. The actual time spent with the patient must be documented to support the multiple units billed. This time has not been supplied by the provider."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 15, 2018	Physical Therapy Services: 97140	$35.74	$22.23

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 using the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - Z710 - The charge for this procedure exceeds the fee schedule allowance.
   - W3 – Request for reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Does the respondent's position statement address only those denial reasons presented to the health care provider before the date Medical Fee Dispute Resolution was requested?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent's position statement discusses new denial reasons or defenses that were not listed among the claim adjustment reason codes given on the submitted explanations of benefits (EOBs).

   Rule §133.307(d)(2)(F) requires that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   No documentation was found to support that the respondent presented such denial reasons to the requestor during the bill review process, upon reconsideration, or at any time before the date the provider requested Medical Fee Dispute Resolution. Consequently, the division concludes the respondent has waived the right to raise such additional denial reasons or defenses. Any newly raised denial reasons or defenses shall not be considered in this review.

2. This dispute regards medical 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 the geographically adjusted work, practice expense and malpractice values multiplied by the DWC annual conversion factor.

   Medicare's multiple-procedure payment reduction (MPPR) policy requires the first unit of the therapy code with the highest practice expense be paid in full. Payment is reduced by 50% of the practice expense for each extra unit of therapy (codes with multiple-procedure indicator 5) provided on the same date.

   Reimbursement is calculated as follows:

   - Procedure code 97110 has a Work RVU of 0.45 multiplied by the Work GPCI of 1.007 is 0.45315. The practice expense RVU of 0.4 multiplied by the PE GPCI of 0.986 is 0.3944. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.747 is 0.01494. The sum is 0.86249 multiplied by the DWC conversion factor of $58.31 for a MAR of $50.29. The PE for this code is not the highest; payment is reduced by 50% of the practice expense. The PE reduced rate is $38.79 at 4 units is $155.16.
   - Procedure code 97112 has a Work RVU of 0.5 multiplied by the Work GPCI of 1.007 is 0.5035. The practice expense RVU of 0.47 multiplied by the PE GPCI of 0.986 is 0.46342. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.747 is 0.01494. The sum is 0.98186 multiplied by the DWC conversion factor of $58.31 for a MAR of $57.25. The first unit is paid at $57.25. The PE reduced rate is $43.74. The total for 2 units is $100.99.
   - Procedure code 97140 has a Work RVU of 0.43 multiplied by the Work GPCI of 1.007 is 0.43301. The practice expense RVU of 0.35 multiplied by the PE GPCI of 0.986 is 0.3451. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.747 is 0.00747. The sum is 0.78558 multiplied by the DWC conversion factor of $58.31 for a MAR of $45.81. The PE for this code is not the highest; payment is reduced by 50% of the practice expense. The PE reduced rate is $35.75 at 2 units is $71.50.

   The total allowable reimbursement for the disputed services is $327.65. The insurance carrier paid $305.42. The amount due is $22.23. This amount is recommended.

Conclusion

For the reasons above, the division finds that additional payment is due. As a result, the amount ordered is $22.23.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, the division finds the requestor is entitled to additional reimbursement. The division hereby ORDERS the respondent to remit to the requestor $22.23, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	June 14, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). The division must receive the request within twenty days of your receipt of this decision.

The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 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.