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

ARCH INDEMNITY INSURANCE

MFDR Tracking Number

M4-19-4153-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

May 17, 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
January 7, 2019	Professional Medical Services:97110, 97140	$103.40	$0.00

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 with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 59 – Processed based on multiple or concurrent procedure rules.
   - MRCA - This service was reduced in accordance with the Workers' Compensation Fee Schedule rules for Physician Services.
   - B12 – Services not documented in patient's medical records.
   - W3 – Request for reconsideration.
   - ZE10 – Request for reconsideration.

Issues

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

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - B12 – Services not documented in patient's medical records.

   The respondent's position statement explains, "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."

   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." Medicare payment policy requires the provider to document the time supporting each unit of therapy billed.

   The medical record documents 90 minutes total of therapy, specifying that 6 units of therapy were performed. None of the activities documented on the time sheets could be identified as manual therapy. However, the medical bill includes charges totaling 8 units of services, including 2 units of manual therapy.

   The medical record does not support the manual therapy charges as billed; the carrier's denial reason is supported. The carrier allowed payment for one unit of manual therapy. Additional payment for manual therapy cannot be recommended.

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 99214 represents an evaluation. The Work RVU of 1.5 multiplied by the Work GPCI of 1.007 is 1.5105. The practice expense RVU of 1.46 multiplied by the PE GPCI of 0.986 is 1.43956.
     The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.747 is 0.0747. The sum is 3.02476 multiplied by the DWC conversion factor of $59.19 for a MAR of $179.04.
   - Procedure code 99080-73 is a division specific code for a work status report with reimbursement subject to 28 Texas Administrative Code §129.5(i), which requires that "reimbursement shall be $15."
   - 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 $59.19 for a MAR of $51.05. The PE for this code is not the highest, payment is reduced by 50% of the practice expense. The PE reduced rate is $39.38 at 4 units is $157.52.
   - 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 conversion factor of $59.19 for a MAR of $58.12. This code has the highest PE; for each extra therapy unit after the first, payment is reduced by 50% of the practice expense. The first unit is $58.12. The PE reduced rate is $44.40. 2 units total $102.52.
   - 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 $59.19 for a MAR of $46.50. The PE for this code is not the highest, payment is reduced by 50% of the practice expense. The PE reduced rate is $36.29.

   The total allowable reimbursement for the disputed services is $490.37. The insurance carrier paid $504.08. The amount due is $0.00. 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 findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the division finds the requestor has not established that additional payment is due. As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

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.