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 Fort Worth

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-19-4154-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 17, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier only paid 75% on this date of service. Carrier shall not withdraw a preauthorization or concurrent review approval once issued."

Amount in Dispute: $103.41

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company stands on their original review."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 16, 2019	Outpatient Therapy Services	$103.41	$22.58

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 §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment

codes:

- P12 – Processed based on multiple or concurrent procedure rules
- 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

Issues

1. Did the insurance carrier raise a new issue?
2. Is the carrier's reduction of payment supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states in their position, "…The provider must document the time of 23-37 minutes to support 2 units of the code billed. …The checklist provided does not provide the actual time spent."

   28 TAC 133.307 (d)(2)(F) states in pertinent part,

   (F) 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."

   Review of the submitted explanation of benefits did not find any denial for unsupported service. The insurance carrier's position will not be considered in this review.

2. The requestor is seeking additional reimbursement for outpatient therapy services for date of service January 16, 2019. The carrier reduced the allowed amount based on the multiple procedure rules.

   The applicable Division Rule is found in 28 Texas Administrative Code 134.403. The applicable sections are listed below:

   (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

   Compliance with 28 Texas Administrative Code 134.403 (d) requires application of the Medicare Multiple Procedure Payment Reduction (MPPR) implemented April 1, 2013. The MPPR policy may be found in the CMS Claims Processing Manual 100-04, Chapter 5, section 10.7 found at www.cms.gov. The MPPR policy was used in the calculation of the maximum allowable reimbursement shown below.

3. 28 Texas Administrative Code §134.203 (c) (1) states.

   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 MAR is calculated by the DWC Conversion Factor of 59.19/Medicare Conversion Factor 36.0391 multiplied by the Medicare allowable. **To ensure the appropriate application of the MPPR reductions all services billed for each date will be calculated**. The calculation is as follows:

Date of service	CPT Code	Units	Practice Expense Ranking	Medicare Allowed amount	MAR = 59.19/36.0391 x MPPR Allowable	Amount Paid
January 16, 2019	97110	4	0.4	$23.98	$157.54	$157.51
January 16, 2019	97112	2	0.47 **Highest**	$35.39 1st unit $27.03 2nd unit	$58.12 + $44.39 = $102.51	$116.24

January 16, 2019	97140	2	0.35	$22.09	$72.56	$36.28
				Total	$332.61	$310.03

The total allowable reimbursement for the services in dispute is $332.61. The carrier paid $310.03. A remaining balance of $22.58 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 $22.58.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), 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 $22.58, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		June 6, 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.