



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

XL Insurance America Inc

MFDR Tracking Number

M4-19-4225-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

May 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier is not paying according to authorization our facility received regarding this patient."

Amount in Dispute: \$103.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that the provider has been reimbursed in accordance with the Medical Fee Guidelines in the amount of \$310.04."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 18, 2019	97110, 97140	\$103.40	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- 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
 - V340 – CPT code submitted is based on service time and documentation of time spent does not support the number of units billed. Allowance has been reduced accordingly

Issues

1. Are the insurance carrier's reasons for reduction of payment supported?
2. What rule is applicable to reimbursement guidelines?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of \$103.40 for physical therapy services rendered on February 18, 2019. The carrier reduced code 97110 based on multiple procedure rules and 97140 as the documentation of time spent does not support the number of units billed."

28 Texas Administrative Code 134.203 (a) (5) and (b) (1) states in pertinent part,

"Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

(b) 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; correct coding initiatives (CCI) edits; modifiers;

The Centers for Medicare and Medicaid Claims Processing Manual, Chapter 5, states in applicable section 10.7,

Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology.

Full payment is made for the unit or procedure with the highest PE payment.

*For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, **full payment is made for work and malpractice and 50 percent payment is made for the PE for services** submitted on either professional or institutional claims.*

The calculation of the maximum allowable reimbursement with the application of the MPPR discount is shown in the next paragraph.

Review of the Elite Healthcare physical therapy notes for February 18, 2019 indicates the total number of therapy units on page one as "4." The total number of therapy units on page two is "2" for a total of six. The total number of units submitted on the medical bill for the dispute date of service is "8." As the reported billed units was not supported by the total number of documented units, the carrier's denial is supported.

Review of the submitted explanation of benefits found the carrier allowed one unit of code 97140. The maximum allowable reimbursement is found below.

2. 28 Texas Administrative Code 134.203 (c) 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).

The Medicare Multiple Procedure Payment Reduction file is found at:

<https://www.cms.gov/Medicare/Billing/TherapyServices/index.html>

The MAR calculation is as follows:

Date of service	CPT Code	Units	Practice Expense	Allowable	MAR
February 18, 2019	97110	4	0.4	\$23.98	\$157.54
February 18, 2019	97112	2	0.47	\$35.39 1 st unit \$27.03 2 nd unit	\$102.51
February 18, 2019	97140	1 unit allowed by carrier	0.35	\$36.28	\$36.28
				TOTAL	\$296.33

3. The total allowable reimbursement for the services in dispute is \$296.33. The carrier made a total payment of \$310.04. No additional payment is recommended.

Conclusion

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

Signature

Medical Fee Dispute Resolution Officer

June 14, 2019

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.