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

MITSUI SUMITOMO INSURANCE USA, INC.

MFDR Tracking Number

M4-19-4363-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 4, 2019

Response Submitted By

Gallagher Bassett

REQUESTOR'S POSITION SUMMARY

"CARRIER IS TO PAY 80% PAYMENT FOR SERVICES FURNISHED. CARRIER ONLY PAID 27% ON THIS DATE OF SERVICE."

RESPONDENT'S POSITION SUMMARY

"the medical note does not support anything about aquatic therapy… the medical note does not support manual therapy beyond the first unit… the provider was due additional monies for cpt code 97112. The charges were reprocessed and the adjustment has been completed…. (additional $27.04)"

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 30, 2018	Physical Therapy Services	$339.43	$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.

<u>Background</u>

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.
   - MPPT – In accordance with the CMS Physician Fee Schedule guidelines, this service was reduced due to the Physical Therapy Service rule.
   - 112 – Service not furnished directly to the patient and/or not documented.
   - P300 – The amount paid reflects a fee schedule reduction.
   - 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. 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:
   - 112 – Service not furnished directly to the patient and/or not documented.
   - MPPT – In accordance with the CMS Physician Fee Schedule guidelines, this service was reduced due to the Physical Therapy Service rule.

   The respondent's position statement asserts, "the medical note does not support anything about aquatic therapy… the medical note does not support manual therapy beyond the first unit…"

   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."

   Review of the submitted information finds that the medical record does not sufficiently document that aquatic therapy services were performed. The therapy services performed in the water and time spent are not indicated in the flow sheets or encounter note. Manual therapy services were documented in the therapy note however the time spent performing the services is not adequately documented in the note or flowsheets. The division concludes the documentation does not support the services as billed.

   The insurance carrier's denial reasons are supported. Additional payment cannot be recommended for aquatic therapy, and only 1 unit is supported of manual therapy. Reimbursement will be calculated accordingly below.

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 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. 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 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.

   The total allowable reimbursement for the disputed services is $136.74. The documentation submitted to MFDR supports the insurance carrier paid $123.23 initially plus additional payment issued on June 27, 2019 of $27.04, for a total payment of $150.27. Additional payment is not recommended.

Conclusion

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	July 3, 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.