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
Hartford Accident & Indemnity Co

MFDR Tracking Number
M4-19-4440-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 10, 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: $125.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Date of service in dispute was processed in accordance with Texas Workers' Compensation Guidelines."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 12, 2019	Physical therapy services	$125.44	$58.34

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 §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 119 – Benefit maximum for this time period or occurrence has been reached
   - 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules
   - 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. What is Medicare payment policy?
3. What rule is applicable to reimbursement guidelines?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $125.44 for physical therapy services rendered on April 12, 2019. The carrier denied/reduced the services in dispute as, 119 – "Benefit maximum for this time period or occurrence has been reached" and 163 - The charge for this procedure exceeds the unit value and/or the multiple procedure rules."

   Review of the submitted documentation found insufficient evidence to support the basis of the "maximum benefit." The multiple procedure rules are discussed below.

2. 28 TAC 134.203 (b) (1) states in pertinent part,

   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 Medicare payment policy regarding multiple procedure payment reduction is found in the Centers for Medicare and Medicaid Claims Processing Manual, Chapter 5, which 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 health care provider billed for four units of CPT code 97110, two units of code 97112, and two units of 97140. Per the above Medicare payment policy, "full payment is made for the unit or procedure with the highest PE payment." For the disputed services CPT code 97112 has the highest PE payment for each date of service in dispute, so the first unit of 97112 should be paid at the full amount. Reimbursement of the services other than the first unit of 97112 will have the multiple procedure payment reduction applied.

3. 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 services in dispute were provided in Fort Worth, Texas in April 2019. The formula for reimbursement is the Division of Workers Compensation Conversion Factor for 2019 divided by the Medicare Conversion Factor for 2019 multiple by the Medicare Fee amount. The Medicare Multiple Procedure Payment Reduction file is found at:
   https://www.cms.gov/Medicare/Billing/TherapyServices/index.html

For CPT codes 97110, 97112 and 97140 provided in Fort Worth Texas in 2019 the Medicare fee amounts are shown below.

CODE	SHORT DESCRIPTOR	FEE AMOUNT	50% REDUCTION	PRACTICE EXPENSE RVUs
97110	Therapeutic exercises	$31.08	$23.98	0.4
97112	Neuromuscular reeducation	$35.39	$27.03	0.47
97140	Manual therapy	$28.31	$22.09	0.35

For the disputed date of service, the reimbursement for the first unit of 97112 is DWC Conversion Factor 59.19 divided by the Medicare Conversion Factor 36.0391 multiple by $35.39 = $58.12

For the disputed date of service additional unit of 97112 are reimbursable at DWC Conversion Factor 59.19 divided by the Medicare Conversion Factor 36.0391 multiplied by the reduced amount of $27.03 = $44.39

For the disputed date of service units of 97140 are reimbursable at DWC Conversion Factor 59.19 divided by the Medicare Conversion Factor 36.0391 multiplied by the reduced amount of $22.09 = $36.28

For the disputed date of service units of 97110 are reimbursable at DWC Conversion Factor 59.19 divided by the Medicare Conversion Factor 36.0391 multiplied by the reduced amount of $23.98 = $157.54

The Maximum Allowable Reimbursement (MAR) for date of service April 12, 2019 is shown below

Date of service	Submitted Code	Units	MAR per unit	Total MAR
April 12, 2019	97110	4	$39.38	$157.54
April 12, 2019	97112	2	$58.12 1st unit $44.39 2nd unit	$102.51
April 12, 2019	97140	2	$36.28	$72.56
		Total		$332.61

4. The total allowable reimbursement for the services in dispute is $332.61. The carrier made a total payment of $274.27. The remaining balance of $58.34 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 $58.34.

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 $58.34, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		July 9, 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.