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
Arch Indemnity Insurance Co

MFDR Tracking Number
M4-19-4467-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 11, 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: $339.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per Clinical Validation review, no additional monies are due: After reevaluation of the CMS-1500 along with the attached documentation, we will uphold this initial review."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 26, 2018	97113, 97112, 97140	$339.43	$49.28

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:
   - P12 – Workers compensation jurisdictional fee schedule adjustment
   - 59 – Processed based on multiple or concurrent procedure rules
   - 112 – Service not furnished directly to the patient and/or not documented

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is Medicare payment policy?
3. How is the MAR calculated?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $339.43 for physical therapy services rendered on November 26, 2018.

   The insurance carrier denied Code 97113 – Aquatic therapy/exercise as 112 – Service not furnished directly to the patient and/or not documented. Review of the submitted notes found no documentation to support four units of aquatic therapy was provided to the injured worker. This denial is upheld.

   The insurance carrier reduced the remaining charges based on the workers' compensation jurisdictional fee schedule and multiple procedure rules. These reductions are discussed below.

2. The rule applicable the payment is found in 28 TAC 134.203 (b) (1) which 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 two units of CPT 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 the 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 November of 2018. The formula for reimbursement is the Division of Workers Compensation Conversion Factor for 2018 divided by the Medicare Conversion Factor for 2018 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 97112 and 97140 provided in Fort Worth Texas in 2018 the Medicare fee amounts are shown below.

CODE	SHORT DESCRIPTOR	FEE AMOUNT	50% REDUCTION	PRACTICE EXPENSE RVUs
97112	Neuromuscular reeducation	$35.35	$27.01	0.47
97140	Manual therapy	$28.28	$22.07	0.35

The reimbursement for the first unit of 97112 is DWC Conversion Factor 58.31 divided by the Medicare Conversion Factor 35.9996 multiple by $35.35 = $57.26

The additional unit of 97112 is reimbursable at DWC Conversion Factor 58.31 divided by the Medicare Conversion Factor 35.9996 multiplied by the reduced amount of $27.01 = $43.75

Code 97140 is reimbursable at DWC Conversion Factor 58.31 divided by the Medicare Conversion Factor 35.9996 multiplied by the reduced amount of $22.07 = $35.75

The Maximum Allowable Reimbursement (MAR) for date of service November 26, 2018 is shown below.

Date of service	Submitted Code	Units	MAR per unit	Total MAR
November 26, 2018	97112	2	$57.26 1st unit $43.75 2nd unit	$101.01
November 26, 2018	97140	2	$35.75 x 2 = $71.50	$71.50
		Total		$172.51

4. The total allowable reimbursement for the services in dispute is $172.51. The carrier made a total payment of $123.23. The remaining balance of $49.28 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 $49.28.

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 $49.28, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

Signature | Medical Fee Dispute Resolution Officer | July 12, 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.