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 COMPANY

MFDR Tracking Number
M4-19-4648-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 25, 2019

Response Submitted By
No response received

REQUESTOR'S POSITION SUMMARY

"Carrier is not paying according to authorization our facility received regarding this patient."

RESPONDENT'S POSITION SUMMARY

The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 20, 2018	Professional Medical Services	$339.43	$49.26

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.

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 fee guideline for professional medical services.
3. The division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged July 2, 2019. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier has not responded. Accordingly, this decision is based on the information available at the time of review.
4. The insurance carrier reduced payment for the disputed services with these 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.
   - MPPT – In accordance with the CMS Physician Fee Schedule guidelines, this service was reduced due to the Physical Therapy Service rule.
   - W3 – Request for reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did the insurance carrier respond to the request for medical fee dispute resolution (MFDR)?
2. Are the insurance carrier's reasons for denial of payment supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The Austin carrier representative for Arch Indemnity Insurance Company is Flahive, Odgen & Latson, Attorneys at Law, PC, who acknowledged receipt of a copy of the MFDR request on July 2, 2019. Pursuant to Rule §133.307(d)(1), if the division does not receive a response within 14 calendar days of dispute notification, the division may base its decision on the available information. To date, no response has been received; consequently, this decision is based on the information available at the time of review.
2. The insurance carrier denied Aquatic Therapy services, CPT code 97113, with claim adjustment reason code:
   - 112 – Service not furnished directly to the patient and/or not documented.

   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."

   The disputed aquatic therapy services were billed using timed codes. Medicare policy requires the provider to document the stop and start times or the number of minutes performed for each service to support the units billed for each timed procedure. Review of the submitted medical records finds that while the therapy note lists "Aquatic Therapy" among the services performed, no documentation was found for the start or stop times of the therapy, and no indication was found on the flow sheets of the number of minutes spent performing aquatic therapy — or that any aquatic therapy services were performed at all.

   Because the provider failed to appropriately document the disputed aquatic therapy, the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.
3. 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 payment in full for the first unit of therapy with the highest practice expense. Payment is reduced by 50% of the practice expense for each extra therapy unit (codes with multiple-procedure indicator 5) provided on the same day.

   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 unit of the code with the highest PE, 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 at 2 units is $71.50.

   The total allowable reimbursement for the disputed services is $172.49. The insurance carrier paid $123.23. The amount due is $49.26. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the division finds that additional payment is due. As a result, the amount ordered is $49.26.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, the division finds the requestor is entitled to additional reimbursement. The division hereby ORDERS the respondent to remit to the requestor $49.26, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	August 30, 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.