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**
M4-19-4662-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
June 25, 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:** "CPT 97113 (X4) denied as CV: Documented procedure does not appear to match the code description of the CPT code billed. CPT 97140 (x2) allowed one unit as: CPT code submitted is based on service time and documentation of time spend does not support the number of units billed. Allowance has been reduced accordingly. …(additional $27.02) was finalized in our system today and should be available in Risfacs within 24-48 hours.."

**Response Submitted by:** Gallagher Bassett

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| December 6, 2018 | Physical therapy services | $339.43 | $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**

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
- 112 – Service not furnished directly to the patient and/or not documented
- 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.

**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 $339.43 for physical therapy services rendered December 6, 2018. The carrier denied Code 97113 as 112 – "Service not furnished directly to the patient and/or documented." Review of the submitted medical note found nothing to support the claimant received 97713 – "Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercised." The insurance carrier's denial is supported.

   The insurance carrier reduced the allowed units of Code 97140 – Manual therapy techniques, "This code requires direct contact of the health care provider with the patient…" from two units to one. Review of the submitted "Note" indicates 90 minutes that included treadmill, thoracic stretching, core work/planks, ab crunch, back hyper, McKenzie's, PFN stretches (upper extremity), PNF stretches (lower extremities). The "Encounter" states, Therapeutic Exercises were performed. Mobilization was performed, Manual traction was performed. Proprioceptive neuromuscular facilitation techniques were performed, Co-ordination techniques were performed." The description of the timed units does not match the narrative of the "Encounter" notes. No additional reimbursement is recommended.

   The remaining reduction of payment amount based on the workers' compensation fee schedule and multiple procedure payment rules is 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 97113, two units of CPT code 97112, 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 that were allowed, CPT code 97112 has the highest PE payment 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. The applicable fee guideline is found in 28 Texas Administrative Code §134.203 (c) which 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 Fort Worth, Texas in December 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 |

For the date of service, 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

Units of 97140 are 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 12, 2018 in Fort Worth Texas is:

| Date of service | Submitted Code | Units | MAR per unit | Total MAR |
|---|---|---|---|---|
| December 6, 2018 | 97113 | 4 | Not supported by submitted documentation | |
| December 6, 2018 | 97112 | 2 | $57.26 1st unit<br>$43.75 2nd unit | $101.01 |
| December 6, 2018 | 97140 | 1 | $35.75 | $35.75 |
| | | Total | | $136.75 |

4. The total allowable reimbursement for the services in dispute is $136.76. The carrier made a total payment of $123.23 (additional $27.02 processed) for a total of $150.25. 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**

| | | July 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, 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**.