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
Zurich American Insurance Co

MFDR Tracking Number
M4-19-4672-01

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: $55.87

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per Clinical Validation review, no additional monies are due. The provider billed 97140 (2units), which would be 23-37 minutes of this manual therapy code for items such as mobilization/manipulation, manual lymphatic drainage or traction, etc."

Response Submitted by: Gallagher Bassett Services, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 2, 2018	Physical therapy	$55.87	$55.87

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

Issues

1. What rule is applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $55.87 for physical therapy services rendered August 2, 2018. The carrier reduced the payment amount based on the workers' compensation jurisdictional fee schedule and multiple or concurrent procedure rules.

   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 August 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.

   To correct apply the multiple procedure payment reduction all services performed on the date of service in dispute will have the allowable calculated. 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 2018 the Medicare fee amounts are shown below.

CODE	SHORT DESCRIPTOR	FEE AMOUNT	50% REDUCTION	PRACTICE EXPENSE RVUs
97110	Therapeutic exercises	$31.05	$23.95	0.4
97112	Neuromuscular reeducation	$35.35	$27.01	0.47
97140	Manual therapy	$28.28	$22.07	0.35

   For the date of service in dispute the reimbursement for the first unit of 97112 is DWC Conversion Factor 58.31 divided by the Medicare Conversion Factor 35.9996 multiplied by $35.35 = $57.26

   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 97110 is reimbursable at DWC Conversion Factor 58.31 divided by the Medicare Conversion Factor 35.9996 multiplied by the reduced amount of $23.95 = $38.79

   Units of 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 August 2, 2018 is shown below.

Date of service	Submitted Code	Units	MAR per unit	Total MAR
August 2, 2018	97110	4	$38.79 x 4 = $155.17	$155.17
August 2, 2018	97112	2	$57.26 for 1st unit, $43.75 for 2nd unit	$101.01
August 2, 2018	97140	2	$35.75 x 2 = $71.50	$71.50
		Total		$327.68

2. The total allowable reimbursement for the date of service in dispute is $327.68. The carrier made a total payment of $182.19. The requestor is seeking $55.87. This amount is recommended.

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 $55.87.

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 $55.87, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		July 18, 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.