TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE FORT WORTH

Respondent Name
ARCH INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-19-4683-01

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 19, 2018	Physical Therapy 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 (DWC).

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 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.
   - MPPT – In accordance with the CMS Physician Fee Schedule guidelines, this service was reduced due to the Physical Therapy Service rule.
   - 112 – Service not furnished directly to the patient and/or not documented.
   - 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 response for consideration in this review?
2. Are the insurance carrier's reasons for denial or reduction 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.

   Per 28 Texas Administrative Code §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 disputed aquatic therapy services 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 a timed code (CPT code 97113). 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 each aquatic therapy component— 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 for procedure code 97113.

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. 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 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. 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 PE for this code is not the highest. 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

For the reasons above, DWC 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	September 13, 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 28 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.