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
GRAPEVINE COLLEYVILLE ISD

MFDR Tracking Number
M4-19-5218-01

Carrier's Austin Representative
Box Number 55

MFDR Date Received
August 16,2019

Response Submitted By
York

REQUESTOR'S POSITION SUMMARY

"CARRIER IS NOT PAYING ACCORDING TO AUTHORIZATION OUR FACILITY RECEIVED REGARDING THIS PATIENT."

RESPONDENT'S POSITION SUMMARY

"The reconsideration was denied as the bill was originally paid according to PER SECTION 3134 OF THE AFFORDABLE CARE ACT; MULTIPLE PROCEDURE PAYMENT REDUCTION FOR SELECTED THERAPY SERVICES HAVE BEEN APPLIED TO THIS BILL PER CMS … The reduction applies to … codes contained on the list of 'always therapy' services that are paid under the physician fee schedule…"

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 25, 2019	Physical Therapy Services	$221.53	$154.43

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. 28 Texas Administrative Code §133.240 sets out requirements regarding medical bill payments and denials.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

1. Did the respondent raise new issues or denial reasons that were not presented before the MFDR request?
2. Is the requestor entitled to additional reimbursement?

Findings

1. In their response to this dispute, the insurance carrier raised new defenses or denial reasons that were not found on the explanations of benefits (EOB).

   28 TAC §133.240 sets out required elements that the carrier's EOB must contain, including adjustment reason code(s) conforming to the standards described in DWC rules.

   28 TAC §133.307(d)(2)(F) requires that, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   The insurance carrier's failure to give notice to the health care provider of specific codes or explanations for reduction or denial of payment as required by Rule §133.240 constitutes grounds for DWC to find a waiver of defenses during Medical Fee Dispute Resolution. And such a waiver is found here.

   The respondent raised new denial reasons and defenses in their position statement for which the carrier failed to give any notice to the health care provider during the bill review and reconsideration process or prior to the filing of this dispute. Consequently, the insurance carrier has waived the right to raise such new denial reasons or defenses during MFDR. Any new defenses or denial reasons will not be considered in this review.

2. 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 97110 has a Work RVU of 0.45 multiplied by the Work GPCI of 1.007 is 0.45315. The practice expense RVU of 0.4 multiplied by the PE GPCI of 0.986 is 0.3944. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.747 is 0.01494. The sum is 0.86249 multiplied by the DWC conversion factor of $59.19 for a MAR of $51.05. The PE for this code is not the highest; payment is thus reduced by 50% of the practice expense. The PE reduced rate is $39.38 at 4 units is $157.52. The carrier paid $39.38, leaving a balance remaining due of $118.14.
   - Procedure code 97112 has a DWC reimbursement of $102.52 for 2 units, and the carrier paid $102.52. Payment for this code is not in dispute.
   - 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 $59.19 for a MAR of $46.50. The PE for this code is not the highest; payment is thus reduced by 50% of the practice expense. The PE reduced rate is $36.29 at 2 units is $72.58. The carrier paid $36.29, leaving a balance remaining due of $36.29.

   The total allowable reimbursement for the services is $332.62. The insurance carrier paid $178.19.
   The amount remaining due is $154.43. This amount is recommended.

Conclusion

For the reasons above, the requestor has established that additional payment is due.
As a result, the amount ordered is $154.43.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $154.43, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	September 6, 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.