



# 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**

NEW HAMPSHIRE INSURANCE COMPANY

**MFDR Tracking Number**

M4-19-5220-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

August 16, 2019

**Response Submitted By**

Flahive, Odgen & Latson, Attorneys at Law, PC

#### REQUESTOR'S POSITION SUMMARY

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

#### RESPONDENT'S POSITION SUMMARY

"The provider was reimbursed for all three CPT codes... Those EOBs recommended reimbursement pursuant to the Medical Fee Guidelines."

#### SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 15, 2019	Physical Therapy CPT 97140	\$56.72	\$36.30

#### 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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
- 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.
  - W3 – Request for reconsideration.
  - ZE10 – Request for reconsideration.
  - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

#### Findings

This dispute regards outpatient physical therapy services with reimbursement subject to 28 TAC §134.203(c), which requires the maximum allowable reimbursement (MAR) be determined by applying Medicare payment policies modified by DWC rules. The MAR is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a DWC 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 97140, February 15, 2019, 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 for this date, 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 \$36.28. The balance remaining due is \$36.30. 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.

The requestor has established that additional payment is due. As a result, the amount ordered is \$36.30.

### **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 \$36.30, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

### Authorized Signature

_____	<u>Grayson Richardson</u>	<u>September 13, 2019</u>
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.