



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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Texoma Medical Center

Respondent Name

Texas Mutual Insurance

MFDR Tracking Number

M4-15-1396-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

January 7, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Texoma Medical Center to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule that started 3/01/2008..."

Amount in Dispute: \$216.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual paid all the billed services. No additional payment is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 16 – 28, 2014	Outpatient Hospital Services	\$216.25	\$48.35

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 356 – This outpatient allowance was based on the Medicare's methodology (Part B) plus the markup.
 - 420 – Supplemental payment

Issues

- What is the applicable rule for determining reimbursement for the disputed services?
- What is the recommended payment amount for the services in dispute?
- Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.403 states in pertinent part (h), states in pertinent part, “for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided.” Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c).
2. 28 Texas Administrative Code §134.203 (c) states, “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). Reimbursement for the disputed services is calculated as follows:
 - Procedure code 97140 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest practice expense for this date. The reduced rate listed for this code in the Multiple Procedure Payment Reduction Rate File for 2014 is \$28.82. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$34.64
 - Procedure code 97530 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest practice expense for this date. The rate listed for this code in the Multiple Procedure Payment Reduction Rate File for 2014 is \$33.45. Each additional unit is paid at \$24.75. The Medicare payment rate for 3 units is \$82.95. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$129.09
 - Procedure code 97140, date of service January 21, 2014, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest practice expense for this date. The reduced rate listed for this code in the Multiple Procedure Payment Reduction Rate File for 2014 is \$28.82. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$34.64
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- Procedure code 97140, date of service January 28, 2014, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest practice expense for this date. The reduced rate listed for this code in the Multiple Procedure Payment Reduction Rate File for 2014 is \$28.82. This amount divided by the Medicare conversion factor of 35.8228 and multiplied by the Division conversion factor of 55.75 yields a MAR of \$34.64
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3. The total allowable reimbursement for the services in dispute is \$654.92. This amount less the amount previously paid by the insurance carrier of \$606.57 leaves an amount due to the requestor of \$48.35. 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 \$48.35.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$48.35, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

April , 2015

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §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 MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **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.