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
Texas Health Arlington

Respondent Name
QBE Insurance Corporation

MFDR Tracking Number
M4-18-3827-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 5, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…payment for services provided to the above reference patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $14.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider was entitled to reimbursement of $150.87 for each date of service under CPT code 97110. The provider has been reimbursed that amount. The provider is not entitled to any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 4th and 11th, 2018	Outpatient Therapy Services	$14.16	$0.00

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 §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is the carrier's reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient therapy services performed from January 4th and 11th, 2018. The carrier reduced the allowed amount as P12 – "Workers' compensation jurisdictional fee schedule amount."

   The applicable Division Rule is found in 28 Texas Administrative Code 134.403. The applicable sections are listed below:

   > (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided
   >
   > (f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register.
   >
   > (h) For medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

   The OPPS reimbursement formula factors are found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. The specific factor is the Status Indicators. The status indicator for each of the HCPCs code listed on the DWC060 have an "A" status indicator which is defined as, "Not paid under OPPS. Paid by MACs under a fee schedule or payment system other than OPPS."

   Based on the requirements of 28 Texas Administrative Code 134.403 (h) the applicable Division fee Guideline is found in 28 Texas Administrative Code §134.203.

   On April 1st of 2013, Medicare implemented the Medicare Multiple Procedure Payment Reduction (MPPR). The MPPR policy may be found in the CMS Claims Processing Manual 100-04, Chapter 5, section 10.7 found at www.cms.gov. The MPPR policy applies therefore the carrier's reduction does apply and was used in the calculation of the maximum allowable reimbursement shown below.

2. 28 Texas Administrative Code §134.203 (c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   The MAR is calculated by the DWC Conversion Factor/Medicare Conversion Factor multiplied by the Medicare allowable. The calculation is as follows:

   - Procedure code 97110, billed January 4, 2018 for three units was on the only service provided for this date. The first unit will be reimbursed at the full allowable of $30.28. The second and third units will be reimbursed at the reduced rate of $23.53. 58.31/35.9996 x $30.28 = $49.05. 58.31/35.9996 x $23.53 x 2 units = $76.22. $49.05 + $76.22 = $125.27
   - Procedure code 97110, billed January 11, 2018 for three units was on the only service provided for this date. The first unit will be reimbursed at the full allowable of $30.28. The second and third units will

be reimbursed at the reduced rate of $23.53. 58.31/35.9996 x $30.28 = $49.05. 58.31/35.9996 x $23.53 x 2 units = $76.22. $49.05 + $76.22 = $125.27

The total allowable reimbursement for the services in dispute is $250.54. The carrier paid $301.74. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		July 12, 2018
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.