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 Fort Worth

**Respondent Name**
Hartford Casualty Insurance Co

**MFDR Tracking Number**
M4-18-4388-01

**Carrier's Austin Representative**
Box Number 47

**MFDR Date Received**
July 20, 2018

## *REQUESTOR'S POSITION SUMMARY*

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

**Amount in Dispute:** $20.10

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Services were processed in accordance with Texas Guidelines, Rule 134.403."

**Response Submitted by:** The Hartford

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 17, 2018<br>April 27, 2018 | 97140 GP<br>97140 GP | $10.05<br>$10.05 | $20.10 |

## *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 §134.203 sets out the reimbursement guidelines 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
   - 119 – Benefit maximum for this time period or occurrence has been reached
   - 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules

**Issues**

1. Are the insurance carrier's reasons for reduction of payment supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. The requestor is seeking additional reimbursement of $20.10 for Procedure Code 97140 on dates of service April 17th and 27, 2018. The insurance carrier reduced the disputed services with claim adjustment reason code P12 – "Workers compensation jurisdictional fee schedule adjustment."

   28 Texas Administrative Code §134.203 sets out the medical fee guideline for professional services and contains the following applicable rules.

   > (a)(5) "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.
   >
   > (b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided."

   The Medicare payment policy is found in the Medicare Claims Processing Manual, Chapter 5, Section, 10.7 which states in pertinent part,

   > *Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures.*
   >
   > *For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 50 percent payment is made for the PE for services submitted on either professional or institutional claims.*
   >
   > *To determine which services will receive the MPPR, contractors shall rank services according to the applicable PE relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services.*

   The calculation of the fee schedule amount is shown below.

2. 28 Texas Administrative Code §134.203 (c) states in pertinent part,

   > 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)

   The maximum allowable reimbursement in calculated as follows:

   - Procedure code 97140, billed April 17, 2018 has a PE of 0.35 the highest for this date. This procedure will receive the full allowable of $28.28. 58.31/35.9996 x $28.28 = $45.81. The carrier paid $35.75 leaving a balance of $10.06. The requestor is seeking $10.05. This amount is recommended.
   - Procedure code 97140, billed August 27, 2018 has a PE of 0.35 the highest for this date. This procedure will receive the full allowable of $28.28. 58.31/35.9996 x $28.28 = $45.81. The carrier paid $35.75 leaving a balance of $10.06. The requestor is seeking $10.05. 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 $20.10

## *ORDER*

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $20.10, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

**Authorized Signature**

| | | |
|---|---|---|
| | | August 17, 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**.