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
Texas Health Fort Worth

Respondent Name
Hartford Casualty Insurance Co

MFDR Tracking Number
M4-18-4431-01

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: $97.70

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
May 1 - 31, 2018	Outpatient Therapy Services	$97.70	$4.60

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 guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment

codes:

- 107 – Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim
- 246 – This procedure is inappropriately billed it should only be billed in conjunction with appropriate required code
- 119 – Benefit maximum for this time period or occurrence has been reached
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules
- 170 – Reimbursement is based on the outpatient/inpatient fee schedule

Issues

1. Is the carrier's denial of payment supported?
2. What rule is applicable to disputed services?
3. What rule defines calculation of the fee?
4. Is the requestor due an additional payment?

Findings

The requestor is seeking additional reimbursement for outpatient therapy services performed from May 1 - 31, 2018. The carrier denied Code 97035 -GO on May 1, 2018 and Code G0283 –GO and 97035 –GO on May 31, 2018 as 107 – "Claim/Service denied because the related or qualifying claim/service was not previously paid or identified on this claim."

Review of the submitted medical bill finds the services billed for date of service May 1, 2018 were;

- 97165 GO - Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.
- 97035 GO - Application of a modality to 1 or more areas; ultrasound, each 15 minutes
- G8987 GO CK - Self care functional limitation, current status, at therapy episode outset and at reporting intervals
- G8988 GO CI - Self care functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
- 97010 GO - Application of a modality to 1 or more areas; hot or cold packs

The services billed for date of service May 31, 2018 were;

- G0283 GO - Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
- 97010 GO - Application of a modality to 1 or more areas; hot or cold packs
- 97035 GO - Application of a modality to 1 or more areas; ultrasound, each 15 minutes

28 Texas Administrative Code 134.403 (d) states in pertinent part,

> 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

Review of the applicable Medicare payment policy finds;

> 97035 - *used in conjunction with therapeutic procedures, not as an isolated treatment.*
>
> G0283 - *this modality will be used in a clearly adjunctive role and not as a major component of the therapeutic encounter*.

Based on the above and review of the submitted medical bill, the carrier's denial is supported as no therapeutic services were rendered on May 1, 2018 or May 31, 2018.

2. The remaining services in dispute were reduced by the carrier as P12 – "Workers compensation jurisdictional fee schedule adjustment" and 163 – "The charge for this procedure exceeds the unit value and/or the multiple procedure rules."

   28 Texas Administrative Code 134.403 states in the applicable sections 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.

3. 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 97035, billed May 10, 2018 has a PE of 0.16 not the highest for this date and will be paid at the reduced allowable of $10.72. 58.31/35.9996 x $10.72 = $17.36 the carrier paid $17.36. No additional payment is recommended.

- Procedure code 97035, billed May 15, 2018 has a PE of 0.16 not the highest for this date and will be paid at the reduced allowable of $10.72. 58.31/35.9996 x $10.72 = $17.36 the carrier paid $17.36. No additional payment is recommended.
- Procedure code 97035, billed May 17, 2018 has a PE of 0.16 not the highest for this date and will be paid at the reduced allowable of $10.72. 58.31/35.9996 x $10.72 = $17.36 the carrier paid $17.36. No additional payment is recommended.
- Procedure code 97035, billed May 22, 2018 has a PE of 0.16 the highest for this date and will be paid at the full allowable of $13.56. 58.31/35.9996 x $13.56 = $21.96. The carrier paid $17.36. An additional payment $4.60 is recommended.
- Procedure code 97035, billed May 24, 2018 has a PE of 0.16 not the highest for this date and will be paid at the reduced allowable of $10.72. 58.31/35.9996 x $10.72 = $17.36 the carrier paid $17.36. No additional payment is recommended.
- Procedure code G0283, billed May 24, 2018 has a PE of 0.23 not the highest for this date and will be paid at the reduced allowable of $10.88. 58.31/35.9996 x $10.88 = $17.62. The carrier paid $17.62. No additional payment is recommended.

4. Based on the applicable Medicare payment policy and Division fee guidelines, an additional payment of $4.60 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 $4.60.

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 $4.60, 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.