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 Plano

Respondent Name
Hartford Casualty Insurance Co

MFDR Tracking Number
M4-19-1925-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
December 5, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Physical therapy services have not been reimbursed per state fee schedule rules. PT services billed by a hospital on a UB are paid using the CMS calculation with the appropriate hospital uplift."

Amount in Dispute: $119.95

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
July 6 – 26, 2018	Outpatient Therapy Services	$119.95	$11.50

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:
   - 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
   - 170 – Reimbursement is based on the outpatient/inpatient fee schedule
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is the carrier's reduction of payment supported?
2. What rule(s) are applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient therapy services performed from July 6 – 26, 2018. The carrier reduced the allowed amount as P12 – "Workers' compensation jurisdictional fee schedule amount," 119 – "The benefit maximum for this time period or occurrence has been reached," and 163 – "The charge for this procedure exceeds the unit value and/or the multiple procedure rules" and 906 – "In accordance with clinical based coding edits (National correct coding initiative/outpatient code editor). Component code of comprehensive medication, evaluation and management services procedure (9000-99999) has been disallowed."

   Review of the Medicare Claims Processing Manual, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html , Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services 20.2 – D, which states in pertinent part,

   > *Reporting of Service Units With HCPCS, D. Specific Limits for HCPCS. The Deficit Reduction Act of 2005, section 5107 requires the implementation of clinically appropriate code edits to eliminate improper payments for outpatient therapy services. The following codes may be billed, when covered, only at or below the number of units indicated on the chart per treatment day.*

   However, the codes in dispute 97110 and 97140 are not listed on this chart. Therefore, the carrier's denial limit of units for these codes is not supported. The applicable fee will be calculated below.

   Review of the National Correct Coding Initiative (NCCI) edits found an edit does exist between Code 97164 and Code 97140 and 97110. The carrier's denial of Code 97164 is supported no additional payment is recommended.

2. The applicable Division Rule regarding reimbursement 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
   >
   > (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.

Compliance with 28 Texas Administrative Code 134.403 (d) requires application of the Medicare Multiple Procedure Payment Reduction (MPPR) implemented April 1, 2013. 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 was used in the calculation of the maximum allowable reimbursement shown below.

3. 28 Texas Administrative Code §134.203 (c) (1) 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).

   The MAR is calculated by the DWC Conversion Factor of 58.31/Medicare Conversion Factor 35.9996 multiplied by the Medicare allowable. **To ensure the appropriate application of the MPPR reductions all services billed for each date will be calculated**. The calculation is as follows:

   - Procedure code 97110, GP billed July 6, 2018 has a PE of 0.4 the highest for this date and will be paid at the full allowable of $31.55. 58.31/35.9996 x $31.55 = $51.10
   - Procedure code 97140, GP billed July 6, 2018 for two units has a PE of 0.35 not the highest for this date and will be paid at the reduce rate of $22.33. 58.31/35.9996 x $22.33 x 2 = $72.34
   - Procedure code 97140, GP billed July 26, 2018 for two units was the only service billed for this date. The first unit will be paid at the full allowable of $28.72. The second unit at $22.33. 58.31/35.9996 x $28.72 = $46.72. 58.31/35.9996 x $22.33 = $36.17. $46.72 + $36.17 = $82.89
   - Procedure code 97110, GO billed July 25, 2018 for two units has a PE of 0.4 the highest for this date. The first unit will be paid at the full allowable of $31.55. The second unit at the reduced rated of $24.25. 58.31/35.9996 x $31.55 = $51.10. 58.31/35.9996 x $24.25 = $39.28. $51.10 + $39.28 = $90.38
   - Procedure code 97140, GO billed July 25, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of $22.33. 58.31/35.9996 x $22.33 = $36.17

The total allowable reimbursement for the services in dispute is $332.88. The carrier paid $321.38. The balance of $11.50 is due to the requestor.

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 $11.50.

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 $11.50 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	January 4, 2019 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.