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 Denton

Respondent Name
Amerisure Mutual Insurance Co

MFDR Tracking Number
M4-19-2832-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
January 22, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the Tx Fee Schedule this claim is underpaid."

Amount in Dispute: $86.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per the submitted DWC 60, the amount in dispute is $86.04 billed for physical therapy services. Amerisure has review the documents provided and Texas First Health Network Fee scheduled and issued an additional EOB showing that no additional allowance is recommended."

Response Submitted by: Amerisure

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2 – 27, 2018	Outpatient Therapy Services	$86.04	$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. 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
5. 28 Texas Administrative Code §§10.120 through 10.122 address the submission of a complaint by a health

care provider to the Health Care Network.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 59 – Processed based on multiple or concurrent procedure rules

Issues

1. Is the carrier's position statement supported?
2. Is the carrier's reduction and denial of payment supported?
3. What rules apply to the payable amounts?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier states, "Amerisure has found this claim to be in the Texas First Health healthcare network and therefore, this is not the appropriate forum for this dispute." Review of the information available to the Division found the claimant's effective date for network coverage is July 16, 2018. The dates of service July 2, 3, 9, 5, 10, and 13, 2018 will be reviewed per applicable DWC rules and fee guidelines.

   Regarding dates of service July 17, 20 and 27, 2018. Medical fee dispute resolution at the Division of Workers' Compensation is not the appropriate administrative process to resolve a question regarding a Network payment reduction. Pursuant to Texas Insurance Code Subchapter I,[1] the Network complaint process outlined in the policies and procedures of the certified healthcare network is the appropriate remedy. Additionally, the Division notes that requestor may also choose to file a complaint with the Texas Department of Insurance.[2]

   The TDI rules at 28 Texas Administrative Code §§10.120 through 10.122 address the submission of a complaint by a health care provider to the Health Care Network. The Division finds that the disputed services rendered by an in-network healthcare facility to an in-network injured employee may be filed to the Texas Department of Insurance's (TDI) Complaint Resolution Process, if the health care provider or facility is dissatisfied with the outcome of the network complaint process. The complaint process outlined in Texas Insurance Code Subchapter I, §1305.401 - §1305.405 may be the appropriate administrative remedy to address fee matters related to health care certified networks.

   The dispute is resolved by the Division pursuant to Division rules, including §133.307 of this title (relating to MDR of Fee Disputes." The Division defines non-network health care in paragraph (a) (6) of the same rule as "Health care not delivered or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules …" That is, the Divisions medical fee dispute

---

[1] SUBCHAPTER I. COMPLAINT RESOLUTION

Sec. 1305.401. COMPLAINT SYSTEM REQUIRED. (a) Each network shall implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint. (b) The network may require a complainant to file the complaint not later than the 90th day after the date of the event or occurrence that is the basis for the complaint. (c) The complaint system must include a process for the notice and appeal of a complaint. (d) The commissioner may adopt rules as necessary to implement this section.

Sec. 1305.402. COMPLAINT INITIATION AND INITIAL RESPONSE; DEADLINES FOR RESPONSE AND RESOLUTION. (a) If a complainant notifies a network of a complaint, the network, not later than the seventh calendar day after the date the network receives the complaint, shall respond to the complainant, acknowledging the date of receipt of the complaint and providing a description of the network's complaint procedures and deadlines. (b) The network shall investigate and resolve a complaint not later than the 30th calendar day after the date the network receives the complaint.

[2] How does a provider file a Workers' Compensation Network complaint?

When submitting a complaint please include your contact information, the injured employee's name, date of birth, claim number, the name of the Certified Workers' Compensation Network and the reason for the complaint. Be specific when explaining the reason for your complaint and include any supporting documentation. If the complaint involves a claim issue, please submit a copy of the claim form (CMS1500, UB04 or ADA), evidence of your collection attempts and evidence of timely claim filing.

Then, email the complaint to ConsumerProtection@tdi.texas.gov; or fax to (512) 490-1007; or mail to Texas Department of Insurance, Consumer Protection, MC 111-1A, P.O. Box 149091, Austin, Texas 78714-9091.

resolution section, may address disputes involving health care provided to an injured employee enrolled in an HCN, only if the out-of-network health care provider was authorized by the certified network to do so.

2. The remaining dates of services were reduced based on "multiple procedure rules."

   The reduction of the allowable based on the multiple procedure rules are applicable to 28 TAC §134.403 (d) which states,

   > 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

   The calculation of the applicable fee based is shown below.

3. 28 TAC §134.403 (f) and (h) determine the reimbursement of the remaining services in dispute and states,

   > (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 (c) (1) which 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 billed July 2, 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 $30.28. The second unit will be paid at the reduced rate of $23.53. 58.31/35.9996 x $30.28 = $49.05. 58.31/35.9996 x $23.53 = $38.11. $49.05 + $38.11 = $87.16
   - Procedure code 97140 billed July 2, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of $21.68. 58.31/35.9996 x $21.68 = $35.12
   - Procedure code 97110 billed July 3, 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 $30.28. The second unit will be paid at the reduced rate of $23.53. 58.31/35.9996 x $30.28 = $49.05. 58.31/35.9996 x $23.53 = $38.11. $49.05 + $38.11 = $87.16
   - Procedure code 97140 billed July 3, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of $21.68. 58.31/35.9996 x $21.68 = $35.12

- Procedure code 97110 billed July 5, 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 $30.28. The second unit will be paid at the reduced rate of $23.53. 58.31/35.9996 x $30.28 = $49.05. 58.31/35.9996 x $23.53 = $38.11. $49.05 + $38.11 = $87.16
- Procedure code 97140 billed July 5, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of $21.68. 58.31/35.9996 x $21.68 = $35.12
- Procedure code 97110 billed July 9, 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 $30.28. The second unit will be paid at the reduced rate of $23.53. 58.31/35.9996 x $30.28 = $49.05. 58.31/35.9996 x $23.53 = $38.11. $49.05 + $38.11 = $87.16
- Procedure code 97140 billed July 9, 2018 for two units has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of $21.68. 58.31/35.9996 x $21.68 x 2 = $70.23
- Procedure code 97530 billed July 10, 2018 has a PE of 0.69 not the highest for this date and will be paid at the reduced rate of $28.06. 58.31/35.9996 x $28.06 = $45.45
- Procedure code 97110 billed July 10, 2018 has a PE of 0.4 the highest for this date and will be paid at the full allowable of $30.28. 58.31/35.9996 x $30.28 = $49.05
- Procedure code 97140 billed July 10, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of $21.68. 58.31/35.9996 x $21.68 = $35.12
- Procedure code 97110 billed July 13, 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 $30.28. The second unit will be paid at the reduced rate of $23.53. 58.31/35.9996 x $30.28 = $49.05. 58.31/35.9996 x $23.53 = $38.11. $49.05 + $38.11 = $87.16
- Procedure code 97140 billed July 13, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of $21.68. 58.31/35.9996 x $21.68 = $35.12
- Procedure code 97760 billed July 17, 2018 has a PE of 0.81 not the highest for this date and will be paid at the reduced rate of $32.25. 58.31/35.99996 x $32.25 = $52.24
- Procedure code 97110 billed July 17, 2018 has a PE of 0.4 the highest for this date and will be paid at the full allowable of $30.28. 58.31/35.9996 x $30.28 = $49.05
- Procedure code 97140 billed July 17, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of $21.68. 58.31/35.9996 x $21.68 = $35.12

The total allowable reimbursement for the services in dispute not subject to a network is $776.13. The carrier paid $780.63. 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

		March 27, 2019
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.