



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 Plano

Respondent Name

Hartford Casualty Co

MFDR Tracking Number

M4-19-3065-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

February 8, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per CCI edits, modifier 59 overrides this rule."

Amount in Dispute: \$413.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dates of service in dispute was processed in accordance with Texas Workers' Compensation Guidelines, Rules 134.403, 134.203 (c)."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 10 – 31, 2018	Outpatient Therapy Services	\$413.92	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- 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
- 236 – Procedure not reimbursable during same visit for the similar service
- 246 – This procedure is inappropriately billed. It should only be billed in conjunction with appropriate required code
- 906 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

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

Findings

1. The requestor is seeking additional reimbursement for outpatient therapy services performed from May 10 – 31, 2019. 28 TAC 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

The carrier denied these services on the following dates of service (DOS) as follows:

- 97140, DOS May 11, 2018 – 906/In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed. Review of the Medicare CCI edits found an edit exists between code 97140 and 97012. The carrier's denial is supported.
- 97018 -59, DOS May 16, 2018 – 906/In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed. Review of the Medicare CCI edits found an edit exists between code 97018 and code 97140. While the provider used modifier -59, no documentation was found to support a separate and distinct procedure. The carrier's denial is supported.
- 97140, DOS May 18, 2018 – 906/In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed. Review of the Medicare CCI edits found an edit exists between code 97140 and 97012. The carrier's denial is supported.
- 97018 -59, DOS May 24, 2018 – 236/Procedure not reimbursable during same visit for the similar service. Review of the Medicare CCI edits found an edit exists between code 97018 and 97140. While the provider used modifier -59, no documentation was found to support a separate and distinct procedure. The carrier's denial is supported.
- 97018 -59, DOS May 29, 2018 – 236/Procedure not reimbursable during same visit for the similar service. Review of the Medicare CCI edits found an edit exists between code 97018 and 97140. While the provider used modifier -59, no documentation was found to support a separate and distinct procedure. The carrier's denial is supported.

- 97018 -59, DOS May 31, 2018 – 236/Procedure not reimbursable during same visit for the similar service. Review of the Medicare CCI edits found an edit exists between code 97018 and 97140. While the provider used modifier -59, no documentation was found to support a separate and distinct procedure. The carrier’s denial is supported.

The remaining services in dispute were reduced in number of units that were allowed or payment amounts. These reductions are discussed below.

2. 28 TAC 134.403 (f) and (h) apply to determining reimbursement amounts of the services in dispute and state in pertinent parts,

(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.

Compliance with 28 Texas Administrative Code 134.403 (d) requires application of the Medicare Multiple Procedure Payment Reduction (MPPR) found in the CMS Claims Processing Manual 100-04, Chapter 5, section 10.7 at www.cms.gov. The carrier’s reduction of 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules, is allowed and will be used in the calculation of the appropriate payment for the services in dispute.

Regarding the denial of 119 – Benefit maximum for this time period or occurrence has been reached. 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.

The codes in dispute 97140, 97035, 97022, 97012 are not listed on this chart. This denial is not supported.

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 97140 billed May 10, 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 \times \$21.68 \times 2 = \70.23
- Procedure code 97110 billed May 10, 2018 has a PE of 0.4 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 \times \$30.28 = \49.05
- Procedure code 97012 billed May 10, 2018 has a PE of 0.16 not the highest for this date and will be paid at the reduced rate of \$11.99. $58.31/35.9996 \times \$11.99 = \19.42
- Procedure code 97140 billed May 11, 2018 as shown above has a CCI edit no additional payment recommended.
- Procedure code 97012 billed May 11, 2018 has a PE of 0.16 not the highest for this date and will be paid at the reduced rate of \$11.99. $58.31/35.9996 \times \$11.99 = \19.42
- Procedure code 97022 billed May 15, 2018 has a PE of .36 not the highest for this date and will be paid at the reduced rate of \$12.48. $58.31/35.9996 \times \$12.48 = \20.21
- Procedure code 97110 billed May 15, 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 \times \$30.28 = \49.05
- Procedure code 97140 billed May 15, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of \$21.68. $58.31/35.996 \times \$21.68 = \35.12
- 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 rate of \$10.55. $58.31/35.9996 \times \$10.55 = \17.09
- Procedure code 97140 billed May 16, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of \$21.68. $58.31/35.996 \times \$21.68 = \35.12
- Procedure code 97110 billed May 16, 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 \times \$30.28 = \49.05
- Procedure code 97035 billed May 16, 2018 has a PE of 0.16 not the highest for this date and will be paid at the reduced rate of \$10.55. $58.31/35.9996 \times \$10.55 = \17.09
- Procedure code billed 97018 May 16, 2018 has a CCI edit. No additional payment is recommended.
- Procedure code 97110 billed May 18, 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 \times \$30.28 = \49.05
- Procedure code 97140 billed May 18, 2018 for three units has a CCI edit. No separate reimbursement is recommended.
- Procedure code 97012 billed May 18, 2018 has a PE of 0.16 not the highest for this date and will be paid at the reduced rate of \$11.99. $58.31/35.9996 \times \$11.99 = \19.42
- Procedure code 97140 billed May 24, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of \$21.68. $58.31/35.996 \times \$21.68 = \35.12
- Procedure code 97110 billed May 24, 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 \times \$30.28 = \49.05
- 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 rate of \$10.55. $58.31/35.9996 \times \$10.55 = \17.09
- Procedure code 97018 billed May 24, 2018 has a CCI edit. No separate payment is recommended.

- Procedure code 97140 billed May 29, 2018 has a PE of 0.35 not the highest for this date and will be paid at the reduced rate of \$21.68. $58.31/35.996 \times \$21.68 = \35.12
- Procedure code 97110 billed May 29, 2018 of 0.4 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 \times \$30.28 = \49.05
- Procedure code 97035 billed May 29, 2018 has a PE of 0.16 not the highest for this date and will be paid at the reduced rate of \$10.55. $58.31/35.9996 \times \$10.55 = \17.09
- Procedure code 97018 billed May 29, 2018 has a CCI edit. No separate payment is recommended
- Procedure code 97110 billed May 31, 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 \times \$30.28 = \49.05
- Procedure code 97035 billed May 31, 2018 has a PE of 0.16 not the highest for this date and will be paid at the reduced rate of \$10.55. $58.31/35.9996 \times \$10.55 = \17.09
- Procedure code 97018 billed May 31, 2018 has a CCI edit. No separate payment is recommended
- Procedure code 97168 billed May 31, 2018 has a PE of 0.97 not the highest for this date and will be at the reduced allowable of \$44.24. $53.81/35.9996 \times \$44.24 = \71.66

The total allowable reimbursement for the services in dispute is \$789.63. The carrier paid \$809.59. 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

Signature

Medical Fee Dispute Resolution Officer

March , 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.