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 HEB

Respondent Name
Hartford Casualty Insurance Co

MFDR Tracking Number
M4-19-3731-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
April 8, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for service provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $16.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Date of service in dispute was processed in accordance with Texas Workers' Compensation Guidelines and 28 TAC 134.403 (d) (f) (h) and 134.203 (c)."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 24, 2018	Outpatient Therapy Services	$16.65	$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. 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. Is the carrier's reduction and denial of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient therapy services performed October 24, 2018. The insurance carrier limited the number of units/allowable based on "benefit maximum" and multiple procedure rules."

   Review of the submitted documentation found insufficient evidence to support the basis of the "benefit maximum." This denial will not be considered in this review.

   The application of the Medicare Multiple Procedure Payment Reduction (MPPR) is applicable as 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 CMS Claims Processing Manual 100-04, Chapter 5, section 10.7 at www.cms.gov, details MPPR policy.

2. 28 TAC §134.403 (f) and (h) determine the reimbursement of the services in dispute and states,

   > (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 status indicator for each of the HCPCs code listed on the DWC060 has 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 as follows;

Date of service	Billed Code	Practice Expense	Units	Medicare allowable	MAR
October 24, 2018	97110	0.4	2	$23.95	58.31/35.9996 x $23.95 x 2 = $77.59
October 24, 2018	97140	0.35 **Highest**	1	$28.28	58.31/35.9996 x $28.28 = $45.81
October 24, 2018	G0283	0.23	1	$10.88	58.31/35.9996 x $10.88 = $17.62
				Total	$141.02

The total allowable reimbursement for the services in dispute is $141.02. The carrier paid $142.45. 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

		May 7, 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.