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 Co

**MFDR Tracking Number**
M4-19-3846-01

**Carrier's Austin Representative**
Box Number 47

**MFDR Date Received**
April 19, 2019

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.493 and 134.404 of Texas Administrative Code."

**Amount in Dispute:** $559.29

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Dates of service in dispute were processed in accordance with Texas Workers' Compensation Guidelines. 28 TAC §134.403 and §134.203 (c)."

**Response Submitted by:** The Hartford

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| October 2 – 10, 2018 | Outpatient Therapy Services | $559.29 | $73.93 |

## *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
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 107 – Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim
- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules
- 906 – In accordance with clinical based coding edits (National correct coding initiative/outpatient code editor)

**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 from October 2 – 10, 2018. The insurance carrier limited the number of units based on "benefit maximum."

   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 reduction of the allowable based on the multiple procedure rules and denial based on CCI edits are applicable to 28 TAC §134.403 (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

   Review of the CCI edits, https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html, found an edits exit between 97164 and 97018, G0283, 97012, 97140, 97110. Between 97140 and 97012. Between 97018 and 97140, 97012. The carrier's denial of these codes is supported. No additional payment is recommended.

   The application of the Medicare Multiple Procedure Payment Reduction (MPPR) may be found in the CMS Claims Processing Manual 100-04, Chapter 5, section 10.7 at www.cms.gov. The MPPR policy was used in the calculation of the maximum allowable reimbursement shown below.

2. 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:

| Date of service | Submitted Code | PE Value | Allowable | Units | MAR 58.31/35.9996 x Medicare allowable |
|---|---|---|---|---|---|
| October 2, 2018 | 97012GP | 0.16 | $11.99 | 1 | $19.42 |
| October 4, 2018 | 97012 GP | 0.16 | $11.99 | 1 | $19.42 |
| October 9, 2018 | 97012 GP | 0.16 | $11.99 | 1 | $19.42 |
| October 4, 2018 | 97110 GP | 0.4 **Highest** | $30.28 | 1 | $49.05 |
| October 2, 2018 | 97110 GP | 0.4 **Highest** | $30.28 1st unit $23.53 2nd unit | 2 | $49.05 + $38.11 = $87.16 |
| October 8, 2018 | 97110 GP | 0.4 **Highest** | $30.28 | 1 | $49.05 |
| October 4, 2018 | 97140 GP | Denied upheld | | 2 | |
| October 8, 2018 | 97140 GP | 0.35 | $21.68 | 2 | $70.23 |
| October 9, 2018 | 97140 GP | Denied upheld | | 3 | |
| October 10, 2018 | 97140 GP | 0.35 | $21.68 | 2 | $70.23 |
| October 2, 2018 | 97164 GP | Denied upheld | | 1 | |
| October 10, 2018 | 97164 GP | Denied upheld | | 1 | |
| October 8, 2018 | G0283 GP | 0.23 | $10.65 | 1 | $17.25 |
| October 10, 2018 | G0283 GP | 0.23 | $10.65 | 1 | $17.25 |
| October 4, 2018 | 97018 GO | Denied upheld | | 1 | |
| October 10, 2018 | 97018 GO | Denied upheld | | 1 | |
| October 4, 2018 | 97110 | 0.4 reduction applies | $23.53 | 2 | $76.22 |
| October 10, 2018 | 97110 GO | 0.4 **Highest** | $30.28 | 1 | $49.05 |

| October 4, 2018 | 97140 GO | Denied upheld | | 1 | |
|---|---|---|---|---|---|
| October 10, 2018 | 97140 | 0.35 | $21.68 | 2 | $70.23 |
| | | | | Total | $613.98 |

The total allowable reimbursement for the services in dispute is $613.98. The carrier paid $540.05. A balance of $73.93 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 $73.93.

## ***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 $73.93, 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 | May 16, 2019<br>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**.