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 Alliance

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-19-4283-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
May 29, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "PT services billed by a hospital on a UB are paid using the CMS calculation with the appropriate hospital uplift. Physician conversion factors are not applicable."

Amount in Dispute: $81.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill has been reviewed and is pricing correct as procedure code 97110 for 2019 has RVU of .40 which makes is the highest code billed. Fee Schedule has paid 1 unit in the amount of $51.05 and the 2nd unit at the reduced rate of $39.38 making the total payment due for 97110 for each DOS $90.43. Procedure code 97140 for 2019 has RVU of .35 which is not the highest code billed. Fee Schedule has paid each unit in the amount of $36.28."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 3 – 30, 2019	Outpatient Therapy Services	$81.72	$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:
   - 170 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting
   - 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules
   - X598 – Claim has been re-evaluated based on additional documentation submitted; No additional payment due

Issues

1. Is the carrier's reduction of payment supported?
2. How is the multiple procedure payment applied?
3. What rule is applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient therapy services performed from January 3 – 30, 2019. The carrier reduced the allowed based on the multiple procedure rules. The requestor states, "…Physician conversion factors are not applicable."

   28 Texas Administrative Code 134.403 (h) states in pertinent part,

   > 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 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. The requestor's position is not supported.

   28 Texas Administrative Code 134.403 (d) 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 insurance carriers' reduction based on the MPPR policy is supported. The calculation of the maximum allowable reimbursement is shown below.

2. 28 TAC 134.203 (b) (1) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   The Medicare payment policy regarding multiple procedure payment reduction is found in the Centers for Medicare and Medicaid Claims Processing Manual, Chapter 5, which states in applicable section 10.7

Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology.

***Full payment is made for the unit or procedure with the highest PE payment**.*

*For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, **full payment is made for work and malpractice and 50 percent payment is made for the PE for services** submitted on either professional or institutional claims.*

The health care provider on billed for two units of CPT code 97110 and one or two units of CPT code 97140. Per the above Medicare payment policy, "full payment is made for the unit or procedure with the highest PE payment." For the disputed services CPT code 97110 has the highest PE payment for each date of service in dispute, so the first unit of 97110 should be paid at the full amount. Reimbursement of the services other than the first unit of 97110 will have the multiple procedure payment reduction applied.

3. 28 Texas Administrative Code 134.203 (c) states in pertinent part,

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 services in dispute were provided in Fort Worth, Texas in January 2019. The formula for reimbursement is the Division of Workers Compensation Conversion Factor for 2019 divided by the Medicare Conversion Factor for 2019 multiple by the Medicare Fee amount. The Medicare Multiple Procedure Payment Reduction file is found at:
https://www.cms.gov/Medicare/Billing/TherapyServices/index.html

For CPT codes 97110 and 97140 provided in Fort Worth Texas in 2019 the Medicare fee amounts are shown below.

CODE	SHORT DESCRIPTOR	FEE AMOUNT	50% REDUCTION	PRACTICE EXPENSE RVUs
97110	Therapeutic Exercises	$31.08	$23.98	0.4
97140	Manual therapy	$28.31	$22.09	0.35

For each of the below dates of service the reimbursement for the first unit of 97110 is DWC Conversion Factor 59.19 divided by the Medicare Conversion Factor 36.0391 multiple by $31.08 = $51.05

For each of the below dates of service additional units of 97110 are reimbursable at DWC Conversion Factor 59.19 divided by the Medicare Conversion Factor 36.0391 multiplied by the reduced amount of $23.98 = $39.38

For each of the below dates of service units of 97140 are reimbursable at DWC Conversion Factor 59.19 divided by the Medicare Conversion Factor 36.0391 multiplied by the reduced amount of $22.09 = $36.28

The Maximum Allowable Reimbursement (MAR) for dates of service January 3 – 30, 2019 is shown below

Date of service	Submitted Code	Units	MAR per unit	Total MAR
January 3, 2019	97110	2	$51.05 1st unit $39.38 2nd unit	$90.43
January 7, 2019	97110	2	$51.05 1st unit $39.38 2nd unit	$90.43
January 9, 2019	97110	2	$51.05 1st unit $39.38 2nd unit	$90.43
January 14, 2019	97110	2	$51.05 1st unit $39.38 2nd unit	$90.43
January 16, 2019	97110	2	$51.05 1st unit $39.38 2nd unit	$90.43
January 21, 2019	97110	2	$51.05 1st unit $39.38 2nd unit	$90.43
January 23, 2019	97110	2	$51.05 1st unit $39.38 2nd unit	$90.43
January 30, 2019	97110	2	$51.05 1st unit $39.38 2nd unit	$90.43
January 3, 2019	97140	2	$36 .28 per unit	$72.56
January 7, 2019	97140	2	$36 .28 per unit	$72.56
January 9,2019	97140	1	$36.28 per unit	$36.28
January 14, 2019	97140	1	$36.28 per unit	$36.28
January 16, 2019	97140	1	$36.28 per unit	$36.28
January 21, 2019	97140	2	$36 .28 per unit	$72.56
January 23, 2019	97140	2	$36 .28 per unit	$72.56
January 30, 2019	97140	1	$36.28 per unit	$36.28
			Total	$1,158.80

The total allowable reimbursement for the billed services is $1,158.80. The carrier paid $1,158.80. 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

		July 9, 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.