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 Arlington

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-19-4347-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 4, 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 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $300.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has previously responded to this dispute on June 25, 2019. However, we have just learned that the claimant is in the Coventry health Care Network. According, the provider is not eligible for Medical Fee Dispute Resolution."

Response Submitted by: Flahive, Ogden and Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 13 – 27, 2018	Outpatient Therapy Services	$300.05	$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:
   - 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
   - 170 – Reimbursement is based on the outpatient/inpatient fee schedule
   - 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. Is the respondent's position supported?
2. Is the carrier's reduction of payment supported?
3. What rule is determines the maximum allowable reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states, "…we have just learned that the claimant is in the Coventry Health Care Network."

   Although Coventry Health Care Network is listed as a certified network on the Division's webpage, the carrier did not provide convincing evidence that the injured employee is enrolled in this network, nor did the carrier provide documentation to support that the requestor is contracted with Coventry Health Care Network.

   The Division concludes that the carrier failed to support its position. Therefore, the service in dispute will be reviewed per applicable Division fee guideline.

2. The requestor is seeking additional reimbursement for outpatient therapy services performed from December 13 – 27, 2018. The carrier reduced the allowed amount as 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, 906 – In accordance with clinical based coding edits and P12 – Workers' compensation jurisdictional fee schedule adjustment.

   Review of the submitted documentation found insufficient evidence to support the denial of "benefit maximum." Th multiple procedure discount and workers' compensation fee schedule is discussed below in the explanation of the fee guideline.

   The denial of Code 97110 for date of service December 13, 2018 and December 20, 2018 for NCCI edits was reviewed and found the insurance carrier's denial is supported as Code 97110 is bundled with code 97760 for both dates of service. The denial of Code 97140 for date of service December 13, 2018 and December 20, 2018 is supported as Code 97140 is bundled with code 97760 for this date of service.

3. The applicable Division Rule that details the fee guideline is found in 28 Texas Administrative Code 134.403 (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 specific factor for the services in dispute is the status indicator which are found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. 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) implemented April 1, 2013. The MPPR policy may be found in the CMS Claims Processing Manual 100-04, Chapter 5, section 10.7 found at www.cms.gov. The MPPR policy was used in the calculation of the maximum allowable reimbursement shown below.

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.*

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 97165 has the highest PE payment for date of service December 13, 2018 and will paid at the full amount. For date of service December 20, 2018 Code 97660 has the highest PE payment and will be paid at the full amount. Reimbursement of the services other than the those listed above will have the multiple procedure payment reduction applied.

4. 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 Arlington, Texas in December of 2018. The formula for reimbursement is the Division of Workers Compensation Conversion Factor for 2018 divided by the Medicare Conversion Factor for 2018 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, 97760, 97165 and 97140 provided in Arlington Texas in 2018 the Medicare fee amounts are shown below.

CODE	SHORT DESCRIPTOR	FEE AMOUNT	MPPR REDUCTION	PRACTICE EXPENSE RVUs
97110	Therapeutic exercises	$31.05	$23.95	0.4
97140	Manual therapy	28.28	$22.07	0.35
97760	Orthotic mgmt. and training	47.42	$33.04	0.81
97165	OT Eval low complexity	91.70	$68.27	1.32

For date of service, December 13, 2018 the reimbursement for 97165 is at the full amount. DWC Conversion Factor 58.31 divided by the Medicare Conversion Factor 35.9996 multiplied by $91.70 = $148.53

For date of service, December 20, 2018 the reimbursement for 97760 is at the full amount. DWC Conversion Factor 58.31 divided by the Medicare Conversion Factor 35.9996 multiplied by $47.42 = $76.81.

For date of service, December 27, 2018 the reimbursement for 97110 is at the full amount. DWC Conversion Factor 58.31 divided by the Medicare Conversion Factor 35.9996 multiplied by $31.05 = $50.29

The remaining services in dispute will be paid at the reduced amounts shown below.

The Maximum Allowable Reimbursement (MAR) for dates of service December 13 – 27, 2018 is shown below

Date of service	Submitted Code	Units	MAR per unit	Total MAR
December 13, 2018	97110	2	Denied per CCI edits	
December 20,2018	97110	1	Denied per CCI edits	
December 27, 2018	97110	2	$50.29 1st unit $38.79 2nd unit	$89.08
December 13, 2018	97140	1	Denied per CCI edits	
December 20, 2018	97140	2	Denied per CCI edits	
December 27, 2018	97140	2	$35.75 x 2 = $71.50	$71.50
December 13, 2018	97760	1	$53.52	$53.52
December 20, 2018	97760	1	$76.81	$76.81
December 13, 2018	97165	1	$148.53	$148.53
		Total		$439.44

The total allowable reimbursement for the services in dispute is $439.44. The carrier paid $439.44. 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 25, 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.