



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

Frisco ISD

MFDR Tracking Number

M4-19-4496-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

June 14, 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: \$24.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is our position that payment issued has been correct and no additional reimbursement is due."

Response Submitted by: Claims Administrative Services, Inc

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: March 1, 2019, Outpatient Therapy Services, \$24.70, \$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:
 - 356 – This outpatient allowance was based on the Medicare’s methodology (Part B) plus the Texas markup
 - P12 – Workers’ compensation jurisdictional fee schedule adjustment
 - 650 – Allowance is reduced per the multiple procedure payment reduction for selected therapy services

Issues

1. Is the carrier’s reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient therapy services performed on March 1, 2019. The carrier reduced the allowed amount based on the workers’ compensation jurisdictional fee schedule and multiple procedure payment reduction.

The applicable Division Rule is found in 28 Texas Administrative Code 134.403. The applicable sections are listed below:

(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

The OPSS 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 OPSS. Paid by MACs under a fee schedule or payment system other than OPSS.”

Compliance with 28 Texas Administrative Code 134.403 (d) requires application of the Medicare Multiple Procedure Payment Reduction (MPPR) implemented April 1, 2013.

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 one unit of CPT code 97110, one unit of CPT code 97140, and one unit of 97112. 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 97112 has the highest PE payment, so 97112 should be paid at the full amount. Reimbursement of the services other than the first unit of 97112 will have the multiple procedure payment reduction applied.

28 Texas Administrative Code §134.403 (h) states in pertinent part, “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 applicable Division fee guideline is found in 28 Texas Administrative Code §134.203.

2. 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 Plano, Texas in March of 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, 97112 and 97140 provided in Plano, Texas in 2019 the Medicare fee amounts are shown below.

CODE	SHORT DESCRIPTOR	FEE AMOUNT	50% REDUCTION	PRACTICE EXPENSE RVUs
97110	Therapeutic Exercise	\$30.31	\$23.55	0.4
97112	Neuromuscular reeducation	\$34.48	\$26.54	0.47
97140	Manual therapy	\$27.62	\$21.70	0.35

For each of the below dates of service the reimbursement for 97110 is DWC Conversion Factor 59.19 divided by the Medicare Conversion Factor 36.0391 multiplied by the reduced amount of \$23.55 = \$38.68

For each of the below dates of service additional units of 97112 are reimbursable at DWC Conversion Factor 59.19 divided by the Medicare Conversion Factor 36.0391 multiplied by the \$34.38 = \$56.63

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 36.0931 multiplied by the reduced amount of \$21.70 = \$35.64

The Maximum Allowable Reimbursement (MAR) for March 1, 2019 is shown below

Date of service	Submitted Code	Units	MAR per unit	Total MAR
March 1, 2019	97110	1	\$38.68	\$38.68
March 1, 2019	97112	1	\$56.63	\$56.63
March 1, 2019	97140	1	\$35.64	\$35.64
		Total		\$130.95

The total allowable reimbursement for the services in dispute is \$130.95. The carrier paid \$130.95. 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.