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 Rockwall

Respondent Name
Arrowood Indemnity Co

MFDR Tracking Number
M4-19-4710-01

Carrier's Austin Representative
Box Number 11

MFDR Date Received
June 28, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Physical therapy services have not been reimbursed per state fee schedule rules. 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: $78.84

RESPONDENT'S POSITION SUMMARY

The Austin carrier representative for Arrowood Indemnity Co is Cunningham Lindsey Group Ltd who acknowledged receipt of the copy of this medical fee dispute on July 3rd, 2019. 28 Texas Administrative Code §133.307 states, in relevant part:

> (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
> (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

Review of the documentation finds that no response has been received on behalf of the insurance carrier from the Carrier representative to date. The division concludes that carrier failed to respond within the timeframe required by §133.307(d)(1). The division will base its decision on the information available.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 18 – 27, 2018	Outpatient Therapy Services	$78.84	$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 – The care for the procedure exceeds the amount indicated in the fee schedule.

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 from December 18 – 27, 2018. The carrier reduced the allowed based on the workers compensation fee schedule.

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

   > (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.

   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.

2. Applicable 28 TAC 134.203(h) states that the total reimbursement is the lesser of the maximum allowable reimbursement (MAR) and the billed amount.

   The MPPR policy states that:
   - Full payment is made for the unit or procedure with the highest Practice Expense (PE) payment factor; and

- For subsequent units the Practice Expense (PE) payment factor is reduced by 50 percent.

Review of the December 2018 medical bill provided indicates that multiple procedures were billed by the health care provider. In order to determine whether the MPPR applies to the service in dispute, the DWC must rank all the services provided by their PE payment factor.

Here is a chart ranking the PE payment for each of the codes billed by the health care provider on in December of 2018.

CODE	PRACTICE EXPENSE	Medicare Policy
97110	0.4	MPPR applies
97112	**0.47**	**Highest rank, no MPPR**
97140	0.35	MPPR applies

As shown above, code 97110 and 97140 **do not** have the highest PE payment among the services billed by the provider that day, therefore the reduced PE payment applies.

The *MPPR Rate File* that contains the payments for 2018 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

- MPPR rates are published by carrier and locality.
- The services were provided in Rockwall, Texas.
- The carrier code for Texas is 4412 and the locality code for Rockwall is 99.

The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR

The table below illustrates the calculation of the total allowable reimbursement of the services listed on the DWC 060.

Date of Service	Code	Medicare Payment	Maximum Allowable Reimbursement (MAR) §134.203 (c)(1) & (2)	Billed Amount From medical bill	Reimbursement §134.203 (h) Lesser of MAR and billed amount
December 18, 2018	97110	23.53[1]	(58.31÷35.9996) x $23.53 x 2 = $76.22	$312.50	$76.22
December 20, 2018	97110	23.53[1]	(58.31÷35.9996) x $23.53 x 2 = $76.22	$312.50	$76.22
December 26, 2018	97110	23.53[1]	(58.31÷35.9996) x $23.53 x 2 = $76.22	$312.50	$76.22
December 27, 2018	97110	23.53[1]	(58.31÷35.9996) x $23.53 x 2 = $76.22	$312.50	$76.22
December 18, 2018	97140	$21.68[1]	(58.31÷35.9996) x $21.68 = $35.12	$140.50	$35.12
December 20, 2018	97140	$21.68[1]	(58.31÷35.9996) x $21.68 = $35.12	$140.50	$35.12

December 26, 2018	97140	$21.68[1]	(58.31÷35.9996) x $21.68 = $35.12	$140.50	$35.12
December 27, 2018	97140	$21.68[1]	(58.31÷35.9996) x $21.68 = $35.12	$140.50	$35.12
		[1]MPPR reduced payment		Total Allowable Reimbursement	$445.36

The total allowable reimbursement for the services in dispute is $445.36. The carrier paid $445.32. 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

Signature	Medical Fee Dispute Resolution Officer	August 29, 2019 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.