TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health Rockwall

Respondent Name
Arrowood Indemnity Co

MFDR Tracking Number
M4-19-5037-01

Carrier's Austin Representative
Box Number 11

MFDR Date Received
July 30, 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: $63.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 1 -14, 2019	Outpatient Therapy Services	$63.82	$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 – Workers compensation jurisdictional fee schedule adjustment
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly

Issues

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

Findings

The Austin carrier representative for Arrowood Indemnity is Cunningham Lindsey who acknowledged receipt of the copy of this medical fee dispute on August 6, 2018. 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 their carrier representative to date. DWC concludes the insurance carrier failed to respond within the timeframe required by §133.307(d)(1). DWC will base its decision on the information available.

1. The requestor is seeking additional reimbursement for outpatient therapy services performed from February 1 – 14, 2019. The carrier reduced the allowed amount as P12 – "Workers' compensation jurisdictional fee schedule amount."

   The applicable DWC Rule is found in 28 TAC Code §134.403. The first applicable section is (d) which requires Texas workers' compensation system participants to apply the Medicare payment policies in effect on the date of service.

   The Medicare 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."

   Section (h) of Rule §134.403 requires when the provided services are reimbursed using other Medicare fee schedule, reimbursement shall be made using the applicable DWC fee guideline.

   Based on the requirements of 28 TAC §134.403 (h) the applicable Division fee guideline is found in 28 TAC §134.203. The applicable fees are calculated below.

2. 28 TAC 134.203 (b) (1) requires that Texas workers' compensation system participants apply Medicare payment policies.

   The *Centers for Medicare and Medicaid Claims Processing Manual 100-04, Chapter 5 titled Part B Outpatient Rehabilitation and CORF/OPT Services* applies and sets the policies applicable to physical therapy services.

   Review of the Medicare policies finds that the multiple procedure payment reduction (MPPR) applies to the Practice Expense (PE) of certain time-based physical therapy codes when more than one unit or procedure is provided to the same patient on the same day. Medicare publishes a list of the codes subject to MPPR annually.

For 2019 the codes subject to MPPR are found in the *CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files.* Review of that list finds the codes in dispute are subject to MPPR policy.

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 submitted medical bill provided indicates that three 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 in February 2019.

CODE	PRACTICE EXPENSE	Medicare Policy
97110	0.4	MPPR applies
97112	**0.47**	**MPPR does not apply**
97140	0.35	MPPR applies

The *MPPR Rate File* that contains the payments for 2019 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

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

Date of Service	Code	Medicare Payment	Maximum Allowable Reimbursement (MAR) §134.203 (c)(1) & (2)	Medical bill amount	Lesser of MAR and billed amount
February 1, 2019	97110	$23.55[1]	(59.19÷36.0391) x $23.55 x 3 = $116.03	$487.50	$116.03
February 4, 2019	97110	$23.55[1]	(59.19÷36.0391) x $23.55 x 2 = $77.36	$325.00	$77.36
February 11, 2019	97110	$23.55[1]	(59.19÷36.0391) x $23.55 x 2 = $77.36	$325.00	$77.36
February 14, 2019	97110	$23.55[1]	(59.19÷36.0391) x $23.55 x 2 = $77.36	$325.00	$77.36
February 4, 2019	97140	$21.70[1]	(59.19÷36.0391) x $21.70 = $35.64	$146.25	$35.64

February 11, 2019	97140	$21.70[1]	(59.19÷36.0391) x $21.70 = $35.64	$146.25	$35.64
			[1]MPPR reduced payment	Total Allowable Reimbursement	$419.35

Based on the applicable DWC fee guideline rule results in a total reimbursement amount of $419.35 for the services in dispute. The carrier paid $419.40. No additional payment is due.

Authorized Signature

		October 3, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.