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 Alliance

Respondent Name
City of Fort Worth

MFDR Tracking Number
M4-19-5233-01

Carrier's Austin Representative
Box Number 4

MFDR Date Received
August 19, 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: $126.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After review of the Medical Dispute Resolution, Your stands on the original audit results."

Response Submitted by: York

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 5 – 27, 2018	Outpatient physical therapy services	$126.95	$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 services.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for occupational therapy services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 59 – Processed based on multiple or concurrent procedure rules
   - 193 – Original payment decision is being maintained. Upon review it was determined that the claim was processed properly

Issues

1. Are the insurance carrier's reasons for reduction of payment supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for occupational therapy services performed in an outpatient setting. The insurance carrier reduced the allowed amount based on the Medicare multiple procedure payment reduction.

   28 TAC §134.403 (d) requires Texas workers' compensation system participants to apply Medicare payment policies for coding, billing, reporting, and reimbursement of health care in effect on the date a service is provided.

   The Medicare multiple procedure payment policy is found at www.cms.gov, and states in pertinent part,

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

   Based on the above, the insurance carrier's reduction is supported. The fee calculation based on this reduction and the DWC fee guideline is found below.

2. 28 TAC §134.403 (h) details for medical services provided in an outpatient acute care hospital for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline.

   Review of the services in dispute find each has a Medicare Status Indicator of (A) which are paid under Medicare Physician Fee Schedule.

   The MPPR ranking for Fort Worth, Texas that determines which service receives full payment and/or reduction is shown below:

HCPCS Code	Practice Expense	Full allowable	Reduced allowable
97022	0.36		$12.82
97140	0.35		$22.07
97035	0.16		$10.72
97110	0.4 *highest*	$31.05	$23.95

The maximum allowable reimbursement for each code on the disputed date of service is subject to 28 TAC §134.203 (h) or reimbursement shall be the least of the MAR amount or the health care provider's usual and customary charge.

Date of Service	HCPCS Code	Units	Allowable	Billed amount	MAR calculation DWC conversion factor/Medicare Conversion Factor multiplied by Medicare allowable = MAR
December 5, 2018	97022	1	$12.82	$140.50	58.51/35.9996 x $12.82 = $20.77

December 5, 2018	97140	2	$22.07	$281.00	58.51/35.9996 x $22.07 x 2 = $71.50
December 6, 2018	97022	1	$12.82	$140.50	58.51/35.9996 x $12.82 = $20.77
December 6, 2018	97140	1	$22.07	$140.50	58.51/35.9996 x $22.07 = $35.75
December 10, 2018	97022	1	$12.82	$140.50	58.51/35.9996 x $12.82 = $20.77
December 10, 2018	97140	1	$22.07	$140.50	58.51/35.9996 x $22.07 = $35.75
December 13, 2018	97022	1	$12.82	$140.50	58.51/35.9996 x $12.82 = $20.77
December 13, 2018	97140	2	$22.07	$281.00	58.51/35.9996 x $22.07 x 2 = $71.50
December 20, 2018	97022	1	$12.82	$140.50	58.51/35.9996 x $12.82 = $20.77
December 20, 2018	97140	1	$22.07	$140.50	58.51/35.9996 x $22.07 = $35.75
December 27, 2018	97022	1	$12.82	$140.50	58.51/35.9996 x $12.82 = $20.77
December 27, 2018	97140	1	$22.07	$140.50	58.51/35.9996 x $22.07 = $35.75
December 27, 2018	97035	1	$10.72	$118.00	58.51/35.9996 x $10.72 = $17.36
			Total	$2,085.00	$427.98

3. The total allowable for the services in dispute is $427.98. The insurance carrier paid $438.03. No additional payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment 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

		December 10, 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.