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
Doctor's Hospital at Renaissance

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-19-5283-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
August 26, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $1,805.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon notification of this dispute the Office performed a comprehensive review of the medical billing in question received from Doctors Hospital at Renaissance for dates of service 4/11/2019-4/30/2019 and determined that no additional payment is warranted."

Response Submitted by: SORM

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 11 – 30, 2019	Outpatient Therapy Services	$1,805.44	$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/patient fee schedule
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

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

Findings

1. The requestor states in their position statement, "…the MAR shall be by applying the Medicare facility specific amount." 28 TAC §134.403 (h) states in pertinent part,

   > 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 services in dispute are classified as with a status indicator "A" found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. The status indicator is described as "Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS."

   These services are paid under the Physician fee schedule and the DWC medical fee guideline for professional fee services. This calculation is found below.

2. The requestor is seeking additional reimbursement for outpatient therapy services performed from April 11 – 30, 2019. The carrier reduced the allowed based on benefit maximum, multiple procedure rules and workers' compensation fee schedule.

   Review of the IMO Preauthorization Determination Letter dated April 8, 2019 found insufficient evidence to support the benefit maximum denial.

   28 TAC 134.203 (b) (1) instructs participants to apply Medicare payment policies that are in effect on the date of service provided.

   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.

   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 titled *CY 2019 PFS Final Rule Multiple Procedure Payment Reduction Files*. Review of that list find that 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.

CODE	PRACTICE EXPENSE	Medicare Policy
97110	0.4	MPPR applies
97112	0.47	MPPR applies
97530	**0.67**	**Highest rank, no MPPR**

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 Edinburg, Texas.
- The carrier code for Texas is 4412 and the locality code for Edinburg 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 in dispute. 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)	Billed Amount From medical bill	Reimbursement §134.203 (h) Lesser of MAR and billed amount
April 11, 2019	97110	$23.55[1]	(59.19÷36.0391) x ($23.55 x 2 units) = $77.36	$284.00	$77.36
April 11, 2019	97530	$39.08	(59.19÷36.0391) x 39.08 = $64.18	$176.00	$64.18
April 11, 2019	97112	$26.54[1]	(59.19÷36.0391) x $26.54 = $43.59	$142.00	$43.59
April 12, 2019	97530	$39.08	(59.19÷36.0391) x 39.08 = $64.18	$176.00	$64.18
April 12, 2019	97110	$23.55[1]	(59.19÷36.0391) x ($23.55 x 2 units) = $77.36	$284.00	$77.36
April 12, 2019	97112	$26.54[1]	(59.19÷36.0391) x $26.54 = $43.59	$142.00	$43.59
April 16, 2019	97530	$39.08	(59.19÷36.0391) x 39.08 = $64.18	$176.00	$64.18

April 16, 2019	97110	$23.55[1]	(59.19÷36.0391) x ($23.55 x 2 units) = $77.36	$284.00	$77.36
April 16, 2019	97112	$26.54[1]	(59.19÷36.0391) x $26.54 = $43.59	$142.00	$43.59
April 18, 2019	97530	$39.08	(59.19÷36.0391) x 39.08 = $64.18	$176.00	$64.18
April 18, 2019	97110	$23.55[1]	(59.19÷36.0391) x ($23.55 x 2 units) = $77.36	$284.00	$77.36
April 18, 2091	97112	$26.54[1]	(59.19÷36.0391) x $26.54 = $43.59	$142.00	$43.59
April 23, 2019	97530	$39.08	(59.19÷36.0391) x 39.08 = $64.18	$176.00	$64.18
April 23, 2019	97110	$23.55[1]	(59.19÷36.0391) x ($23.55 x 2 units) = $77.36	$284.00	$77.36
April 23, 2019	97112	$26.54[1]	(59.19÷36.0391) x $26.54 = $43.59	$142.00	$43.59
April 26, 2019	97530	$39.08	(59.19÷36.0391) x 39.08 = $64.18	$176.00	$64.18
April 26, 2019	97110	$23.55[1]	(59.19÷36.0391) x ($23.55 x 2 units) = $77.36	$284.00	$77.36
April 26, 2019	97112	$26.54[1]	(59.19÷36.0391) x $26.54 = $43.59	$142.00	$43.59
April 30, 2019	97530	$39.08	(59.19÷36.0391) x 39.08 = $64.18	$176.00	$64.18
April 30, 2019	97110	$23.55[1]	(59.19÷36.0391) x ($23.55 x 2 units) = $77.36	$284.00	$77.36
April 30, 2019	97112	$26.54[1]	(59.19÷36.0391) x $26.54 = $43.59	$142.00	$43.59
			[1]MPPR reduced payment	Total Allowable Reimbursement	$1,295.91

3. The total allowable DWC fee guideline reimbursement amount for the services in dispute is $1,295.91. The carrier paid $1,295.91. No additional reimbursement 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	September 24, 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.