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
BAPTIST SAINT ANTHONY'S HOSPITAL

Respondent Name
AMARILLO ISD

MFDR Tracking Number
M4-20-0060-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
September 9, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute: $127.14

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request.

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
June 4, 2019	Revenue Code 420	$127.14	$127.14

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background
1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 TAC §134.403 sets out the medical fee guidelines for services provided in an outpatient acute care hospital.
4. 28 TAC §134.203, sets out the fee guidelines for reimbursement of professional medical services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent
   - 721 –Per rule 134.600 of the Texas Administrative Code. This procedure requires preauthorization, preauthorization not obtained

Issue(s)
1. Did the insurance carrier respond to the medical fee dispute?
2. Are the insurance carrier's denial reasons supported?
3. What is the applicable rule for determining reimbursement for CPT code 97110-GP?
4. Is the requestor entitled to reimbursement?

Findings

1. The Austin carrier representative for Amarillo ISD is Downs Stanford, P.C. Downs Stanford, P.C., acknowledged receipt of the copy of this medical fee dispute on September 17, 2019. 28 TAC §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under 28 TAC §133.307(d)(1).

2. The insurance carrier denied the disputed services with denial reduction codes 197 and 721 (description provided above.)

   Per 28 TAC §134.600 "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   The requestor submitted a copy of a preauthorization letter issued by RM Review Med, dated May 7, 2019. The following services were partially preauthorized:

Decision Date:	May 7, 2019
Requested Services:	Physical Therapy 3 x week x 6 weeks 97035, 97110, 97140, 97161 and G0283
Determination:	Approved CPT Codes, 97161, 97110, 97140 (Not to exceed 4 units per visit)
Dates of Services:	05/06/2019 to 06/07/20119

   The requestor seeks reimbursement for CPT Code 97110-GP rendered on June 4, 2019 in an outpatient facility. The DWC finds that the requestor rendered the disputed services within the preauthorized timeframes and therefore, the insurance carrier's denial reasons are not supported. The requestor is entitled to reimbursement for CPT Code 97110-GP.

3. The applicable DWC Rule is found in 28 TAC §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

   (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-forService-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 TAC §134.403 (h) the applicable DWC fee Guideline is found in 28 TAC §134.203.

3. 28 TAC §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 applicable Medicare payment policy is in the Centers for Medicare and Medicaid Claims Processing Manual, Chapter 5, section 10.7 states, "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 Medicare Multiple Procedure Payment Reduction file is found at: https://www.cms.gov/Medicare/Billing/TherapyServices/index.html

The calculation of the maximum allowable reimbursement with the applicable reduction(s) is shown below:

Procedure code 97110 rendered on June 4, 2019, has a Work RVU of 0.45 multiplied by the Work GPCI of 1 is 0.45. The practice expense RVU of 0.4 multiplied by the PE GPCI of 0.938 is 0.3752. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.796 is 0.01592. The sum is 0.84112 multiplied by the DWC conversion factor of $59.19 for a MAR of $49.79. For each extra therapy unit after the first unit of the code with the highest PE, payment is reduced by 50% of the practice expense. This code has the highest PE. The first unit is paid at $49.79. The PE reduced rate is $38.68 at 2 units is $77.36. The total is $127.15. The requestor seeks $127.14 therefore this amount is recommended.

4. Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $127.14.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $127.14.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of 127.14 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 15, 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 28 TAC §133.307, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the 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 with the DWC. **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.