



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 Kaufman

Respondent Name

American Interstate Insurance Co

MFDR Tracking Number

M4-20-2036-01

Carrier's Austin Representative

Box Number 1

MFDR Date Received

April 20, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: None submitted.

Amount in Dispute: \$83.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our medical cost containment company; Medata conducted a review of this claim and have confirmed we are providing the correct allowance for these codes based upon Multiple Procedure rule."

Response Submitted by: Amerisafe Risk Service Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 7 – 29, 2019	Outpatient Therapy Services	\$83.76	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers compensation jurisdictional fee schedule adjustment

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 In August 2019. The carrier reduced the allowed amount based on the workers compensation fee schedule.

28 TAC 134.403 applies to outpatient hospital services. Section (h) requires when Medicare reimburses using other Medicare fee schedules, reimbursement is made using the applicable Division Fee Guideline in effect for that service on the date was provided.

The applicable DWC fee guideline for physical therapy is 28 TAC §134.203 (b) (1) which requires the application of Medicare payment policies applicable to professional services which includes the Medicare multiple procedure payment reduction (MPPR) that 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.

The MPPR policy allows for full payment 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 four procedures were billed by the health care provider. In order to determine the MPPR allowable, the services provided are ranked by their PE expense shown below.

Code	Practice Expense	Allowed Amount	Medicare Policy
97035	0.17	\$10.73	MPPR applies
97110	0.4	\$30.31	No MPPR
97140	0.35	\$21.70	MPPR applies
G0283	0.21	\$10.32	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 Kaufman, Texas.
- The carrier code for Texas is 4412 and the locality code for Kaufman is 99.

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

$$(DWC\ Conversion\ Factor \div Medicare\ Conversion\ Factor) \times Medicare\ Payment = MAR$$

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	Units	Medicare Payment	DWC Conversion Factor divided by Medicare Conversion Factor or $59.19 \div 36.0391 = 1.64$	Billed Amount	Lesser of MAR and billed amount
August 15, 2019	97035	1	\$10.73	$\$10.73 \times 1.64 = \17.60	\$122.75	\$17.60
August 19, 2019	97035	1	\$10.73	$\$10.73 \times 1.64 = \17.60	\$122.75	\$17.60
August 22, 2019	97035	1	\$10.73	$\$10.73 \times 1.64 = \17.60	\$122.75	\$17.60
August 26, 2019	97035	1	\$10.73	$\$10.73 \times 1.64 = \17.60	\$122.75	\$17.60
August 29, 2019	97035	1	\$10.73	$\$10.73 \times 1.64 = \17.60	\$122.75	\$17.60
August 7, 2019	97140	1	\$21.70	$\$21.70 \times 1.64 = \35.59	\$146.25	\$35.59
August 13, 2019	97140	2	\$21.70	$\$21.70 \times 1.64 = \71.18	\$292.50	\$71.18
August 15, 2019	97140	2	\$21.70	$\$21.70 \times 1.64 = \71.18	\$292.50	\$71.18
August 19, 2019	97140	1	\$21.70	$\$21.70 \times 1.64 = \35.59	\$146.25	\$35.59
August 29, 2019	97140	2	\$21.70	$\$21.70 \times 1.64 = \71.18	\$292.50	\$71.18
August 7, 2019	G0283	1	\$10.32	$\$10.32 \times 1.64 = \16.97	\$122.75	\$16.97
August 13, 2019	G0283	1	\$10.32	$\$10.32 \times 1.64 = \16.97	\$122.75	\$16.97
Total						\$406.66

2. The total allowable DWC fee guideline reimbursement is \$406.66. The insurance carrier paid \$407.12. 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. 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

May 8, 2020
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.