



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

Doctors Hospital at Renaissance

Respondent Name

Edinburg Consolidated ISD

MFDR Tracking Number

M4-17-0168-01

Carrier's Austin Representative

Box Number 29

MFDR Date Received

September 20, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted

Amount in Dispute: \$1,004.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of an acknowledgement of receipt of the medical fee dispute resolution on September 28, 2016. Texas Administrative Code §133.307 (d) (1) states, "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. 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." As no response was received this dispute will be reviewed based on available information.

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------------------------|--------------------------------------|-------------------|------------|
| June 2, 2016 through June 15, 2016 | Outpatient physical therapy services | \$1,004.32 | \$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 §134.203 sets out the reimbursement guidelines for professional medical services.
- 28 Texas Administrative Code §134.403 sets out reimbursement guidelines for services provided in an

outpatient setting.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 01 – The charge for the procedure exceeds the amount indicated in the fee schedule
 - 96 – Non covered charge(s) At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code)
 - HB – Functional reporting code only no fee schedule reimbursement value is assigned to this service
 - P12 Workers compensation state fee schedule adjustment
 - PJ this code is not paid under outpatient PPS
 - P15 – Workers’ compensation medical treatment guideline adjustment

Issues

1. Is the carrier’s reasons for denial or reduction of payment supported?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The services in dispute are physical therapy services provided in an outpatient setting.

The requestor is seeking an additional payment of \$1,004.32. The carrier made a payment of \$921.60 for these dates of service. The payments were reduced with remark codes P12 – “Workers Compensation State Fee Schedule Adjustment” and 01 – “The charge for the procedure exceeds the amount indicated in the fee schedule.

The maximum allowable reimbursement is calculated below.

2. Review of the submitted medical claims finds the “type of bill” is “131” or Outpatient Hospital. Therefore, these services are subject to provisions of 28 Texas Administrative Code 134.403(d) which states in pertinent part,

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...

The applicable Medicare payment policy can be found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

The resource that define the components used to calculate the Medicare payment for OPSS are found below:

- **APC payment groups** - Each HCPCS code for which separate payment is made under the OPSS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

Review of Addendum B applicable to the June 1 - 15, 2016 dates of service finds the following:

- Procedure codes 97110, 97140, 97112 and 97002 have a status indicator of A denoting services paid under a payment system or fee schedule other than OPSS.

Per 28 Texas Administrative Code §134.403(h),

for outpatient services for which Medicare reimburses using fee schedules other than OPSS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided.

Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, 28 Texas Administrative Code §134.203(c) which states in pertinent part,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

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)

Per 28 Texas Administrative Code §134.403 (b)

For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

Per Medicare Claims Processing Manual found at www.cms.gov, in section, 10.7 - Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services

Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services (see section 20), excluding A/B MAC (B)-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services.

The calculation of the maximum allowable reimbursement as described above is as follows:

- Procedure code 97110, service date June 2, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$38.00.
- Procedure code 97140, service date June 2, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$35.35.
- Procedure code 97112, service date June 2, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at \$51.59.
- Procedure code 97110, service date June 1, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$38.00.
- Procedure code 97140, service date June 1, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$35.35 at 2 units is \$70.70.
- Procedure code 97112, service date June 1, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the

procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at \$51.59.

- Procedure code 97110, service date June 6, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$38.00.
- Procedure code 97140, service date June 6, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$35.35.
- Procedure code 97112, service date June 6, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at \$51.59. The PE reduced rate is \$39.05. The total is \$90.64.
- Procedure code 97110, service date June 8, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$38.00.
- Procedure code 97140, service date June 8, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$35.35.
- Procedure code 97112, service date June 8, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at \$51.59.
- Procedure code 97110, service date June 9, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$38.00.
- Procedure code 97140, service date June 9, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$35.35.
- Procedure code 97112, service date June 9, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at \$51.59.
- Procedure code 97110, service date June 13, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of

the practice expense. This procedure has the highest PE for this date. The first unit is paid at \$49.50. The PE reduced rate is \$38.00. The total is \$87.50.

- Procedure code 97140, service date June 13, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$35.35 at 2 units is \$70.70.
 - Procedure code 97002, service date June 15, 2016. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at \$64.30.
 - Procedure code G8986, service date June 15, 2016, has status indicator Q, denoting a therapy functional information code (used for required reporting purposes only).
 - Procedure code G8985, service date June 15, 2016, has status indicator Q, denoting a therapy functional information code (used for required reporting purposes only).
3. The total allowable reimbursement for the services in dispute is \$921.60. This amount less the amount previously paid by the insurance carrier of \$921.60 leaves an amount due to the requestor of \$0.00. This amount 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 upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November 10, 2016
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 Texas Administrative Code §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 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 with the Division. **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.