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 HEB

Respondent Name
Trumbull Insurance Co

MFDR Tracking Number
M4-18-3301-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 14, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "PT services billed by a hospital on a UB are paid using the CMS calculation with the appropriate hospital uplift. Physician conversion factors are not applicable.

Amount in Dispute: $37.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services were processed in accordance with Texas Fee Schedule & Guidelines."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 1, 2017 January 12, 2017	97035 97140	$37.50	$16.76

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 §134.203 sets out the guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

- 107 – Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim
- 246 – This procedure is inappropriately billed it should only be billed in conjunction with appropriate required code
- 170 – Reimbursement is based on the outpatient/inpatient fee schedule

Issues

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

Findings

1. The requestor is seeking additional reimbursement for Code 97035 on January 1, 2017 and Code 97140 on January 12, 2017. The carrier denied Code 97035 as 107 – "Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim." 28 Texas Administrative Code §134.403 (d) 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

   Review of the applicable Medicare payment policy or Add-On Code Edits, found at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html found no associated edits for Code 97035. The carrier's denial is not supported. This code will be reviewed epr applicable fee guidelines.

   Procedure code 97140 was reduced as P12 – "Workers' compensation jurisdictional fee schedule amount." The applicable Division Rule is found in 28 Texas Administrative Code 134.403. The applicable sections are listed below:

   > (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-for-Service-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 Texas Administrative Code 134.403 (h) the applicable Division fee Guideline is found in 28 Texas Administrative Code §134.203.

   28 Texas Administrative Code §134.203 (c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   The MAR is calculated by the DWC Conversion Factor of 57.5/Medicare Conversion Factor 35.8887 multiplied by the Medicare allowable. The calculation is as follows:

   - Procedure code 97035 billed December 1, 2017. This code has an allowable of $13.25. 57.5/35.8887 x $13.25 = $21.23

- Procedure code 97140 billed December 12, 2017. This code has an allowable of $27.59. 57.5/35.8887 x $27.59 = $44.20

2. The total allowable reimbursement for the services in dispute is $65.43. The carrier paid $48.67. Leaving a balance due of $16.76. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $16.76.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $16.76, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		June 13, 2018
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 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.