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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SUMMIT REHABILITATION CENTERS

Respondent Name
SERVICE LLOYDS INSURANCE COMPANY

MFDR Tracking Number
M4-06-1445-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 4, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DOS 9/10/04 through 10/12/04 and 10/26/04: services were provided by the approved TWCC treating doctor. DOS 10/14/04, 10/20/04, 11/5/04, AND 11/10/04: Services can NOT be considered Global to any other on that date."

Amount in Dispute: $774.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Enclosed herewith is documentation to support the position taken by Respondent, Service Lloyds Insurance with respect to Summit Rehabilitation Centers' request for Medical Dispute Resolution."

Response Submitted by: Harris & Harris, 5300 Bee Caves Road, Building III, Suite 200, Austin, Texas 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 12, 2004 to November 10, 2004	Professional Medical Services	$375.69	$145.08

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §133.301 sets out the procedures for insurance carrier review of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services.
4. 28 Texas Administrative Code §180.22 establishes heath care provider roles and responsibilities.
5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
6. The requestor submitted an amended Table of Disputed Services dated September 8, 2008. The Division will consider the remaining disputed services as indicated in the requestor's amended table as the basis for this review. The amount in dispute will be deemed the amount as listed on the requestor's revised table.

7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers' Compensation State Fee Schedule Adj
   - L – Not TD Approved Treatment

Issues

1. Is the insurance carrier's denial reason supported regarding treatment not approved by the treating doctor?
2. Did the insurance carrier meet the requirements for changing a billing code on a medical bill?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The disputed dates of service were denied upon initial consideration by the insurance carrier with payment exception code L – "Not TD Approved Treatment." Upon reconsideration, the insurance carrier did not maintain this denial reason with respect to date of service November 4, 2004, and issued payment for these disputed services. Consequently, the Division finds that there is no longer any dispute that the services were approved by the treating doctor with respect to date of service November 4, 2004. Although, upon reconsideration, the insurance carrier maintained this denial reason with respect to the services rendered October 12, 2004. Per former Division rule at 28 Texas Administrative Code §180.22, effective March 14, 2002, 27 *Texas Register* 1817, except in the case of an emergency, the injured employee's treating doctor shall "approve or recommend all health care rendered to the employee including, but not limited to, medically reasonable and necessary treatment or evaluation provided through referrals to consulting and referral doctors or other health care providers." Review of Division records finds that the injured employee's treating doctor was Dr. Robert Todd Peterson. The doctor who performed the disputed services was Dr. Marivel Subia. No documentation was found to support an emergency. No documentation was found to support that Dr. Petersen approved the disputed treatments; therefore, the insurance carrier's denial reason for October 12 is supported. Accordingly, additional reimbursement cannot be recommended for date of service October 12, 2004. However, the disputed services rendered November 4, 2004 will be reviewed for payment according to applicable Division rules and fee guidelines.
2. Review of the medical bill for date of service November 4, 2004 finds that the health care provider billed procedure code 99213, for a charge of $70. Review of both submitted explanations of benefits for that date finds that the insurance carrier did not process procedure code 99213, but instead processed the disputed service under procedure code 97140 for the same charged amount. Per 28 Texas Administrative Code §133.301(b), effective July 15, 2000, 25 *Texas Register* 2115, "Neither the insurance carrier nor the carrier's agent shall change a billing code on a medical bill or reimburse treatment(s) and/or service(s) at another billing code's value unless the insurance carrier contacts the sender of the bill and the sender agrees to the change." No documentation was found to support that the sender of the bill agreed to the change. The Division therefore concludes that the insurance carrier has not met the requirements of §133.301(b). Consequently, payment for the disputed service will be calculated according to the reimbursement appropriate to procedure code 99213.
3. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.202(c)(1), effective January 5, 2003, 27 *Texas Register* 4048 and 12304, which requires that to determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%." Reimbursement is calculated as follows:
   - Procedure code 99213, service date November 4, 2004, has a Medicare payment rate of $54.59. This amount multiplied by 125% results in a MAR of $68.24
   - Procedure code 97110, service date November 4, 2004, has a Medicare payment rate of $29.59. This amount multiplied by 125% results in a MAR of $36.99. This amount multiplied by 4 units is 147.96.
4. The total recommended payment for the services in dispute is $216.20. This amount, less the amount previously paid by the insurance carrier of $71.12, leaves an amount due to the requestor of $145.08. 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 $145.08.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $145.08 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

May 2, 2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.