



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

AMERICAN HOME ASSURANCE COMPANY

MFDR Tracking Number

M4-06-2201-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 28, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DOS 3/23/05, 3/29/05, 3/30/05, 4/6/05, and 4/12/05 (99213): The provider followed all the TWCC fee guidelines for these services. . . . 3/15/05 (97140), 3/16/05 (97140), . . . Services can not be considered global or included in any other procedure from the same date. . . . DOS 21/05, 2/7/05, and 20/10/05: No EOBs have been received for these services"

Amount in Dispute: \$716.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable."

Response Submitted by: Flahive, Ogden & Latson, 505 West 12th Street, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 1, 2005 to April 12, 2005	Professional Medical Services	\$716.73	\$238.55

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services.
- 28 Texas Administrative Code §129.5 sets out guidelines regarding work status reports.
- The requestor submitted an amended Table of Disputed Services dated September 14, 2006. 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 above is the amount as listed on the requestor's revised table.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - G – unbundling
 - 113-002– NETWORK IMPORT RE-PRICING – NON-CONTRACTED PROVIDER

- 509-001 – CORRECT CODING INITIATIVE BUNDLE GUIDELINES INDICATE THIS CODE IS A MUTUALLY EXCLUSIVE CODE, CONSIDERED INCLUDED IN ANOTHER CODE ON THE SAME DAY.
- 45 – Charges exceed your contracted/legislated fee arrangement.
- 97 – Payment is included in the allowance for another service/procedure.
- W1 – Workers Compensation State Fee Schedule Adjustment
- 210 – THE VISIT HAS BEEN INCLUDED IN THE TREATMENT PERFORMED.
- 663 – REIMBURSEMENT HAS BEEN CALCULATED ACCORDING TO THE STATE FEE SCHEDULE GUIDELINES.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Should this dispute be dismissed in accordance with the respondent's motion?
3. Does the request include copies of the medical bills as submitted to the carrier for reconsideration?
4. Does the request include a copy of each EOB relevant to the fee dispute or convincing evidence of carrier receipt of the provider request for an EOB?
5. Does the request include documentation of the request for and response to reconsideration or convincing evidence of the carrier's receipt of that request?
6. Has the respondent sent a copy of all medical audit summaries and/or EOBs relevant to the fee dispute, or a statement certifying that the carrier did not receive the provider's disputed billing prior to the request?
7. Are the insurance carrier's denial reasons related to the evaluation and management services supported?
8. What is the recommended payment amount for the services in dispute?
9. What is the recommended payment amount for the work status report?
10. Is the requestor entitled to reimbursement?

Findings

1. No documentation was found to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. The services will therefore be reviewed per applicable Division rules and fee guidelines.
2. The respondent asks the Division to dismiss this dispute, stating that "A provider must make a timely and valid request for reconsideration before requesting medical dispute resolution. . . . the carrier disputes that the provider submitted any claim-specific substantive explanation with its request for reconsideration. Accordingly, that the request was not complete and fails to satisfy the prerequisite for medical dispute resolution. This matter is not ripe for review and should be dismissed pursuant to 28 TAC 133.307(m)(3)." Per former 28 Texas Administrative Code §133.307(m)(3), effective January 1, 2003, 27 *Texas Register* 12282, the Division may dismiss a request for medical fee dispute resolution if the Division "determines that the medical bills in the dispute have not been properly submitted to the carrier for reconsideration pursuant to §133.304." Review of the submitted documentation finds that the medical bills have been properly submitted to the carrier for reconsideration. After thorough review of the submitted documentation, the Division concludes that the respondent's motion for dismissal is without merit, and is therefore denied.
3. Former 28 Texas Administrative Code §133.307(e)(2)(A), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of all medical bill(s) as originally submitted to the carrier for reconsideration." Review of the submitted documentation finds that the request includes a copy of the medical bill(s) as submitted to the carrier for reconsideration. The requestor submitted a certified mail receipt to support insurance carrier receipt of the request(s) for reconsideration. The Division concludes that the requestor has met the requirements of §133.307(e)(2)(A).
4. Former 28 Texas Administrative Code §133.307(e)(2)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of each explanation of benefits (EOB) . . . relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB." Review of the submitted documentation finds that the request does not include copies of any EOBs for dates of service February 1, February 7, and February 10, 2005. However, the requestor has submitted convincing evidence of carrier receipt of the provider request for an EOB. The Division concludes that the requestor met the requirements of §133.307(e)(2)(B).
5. Former 28 Texas Administrative Code §133.307(g)(3)(A), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send "documentation of the request for and response to reconsideration (when a provider is requesting dispute resolution on a carrier reduction or denial of a medical bill) or, if the carrier failed to respond to the request for reconsideration, convincing evidence of the carrier's receipt of that request." Review of the submitted information finds that the requestor has provided documentation of the request for and response to reconsideration or convincing evidence of the carrier's receipt of that request. The Division concludes that the requestor has met the requirements of §133.307(g)(3)(A).

6. 28 Texas Administrative Code §133.307(j)(1)(C), effective January 1, 2003, 27 *Texas Register* 12282, requires that each response, unless previously provided in the request and requestor's additional documentation, shall include "a copy of all medical audit summaries and/or explanations of benefits (EOBs) relevant to the fee dispute, or a statement certifying that the carrier did not receive the provider's disputed billing prior to the request." Review of the submitted documentation finds that the respondent has not provided a copy of all medical audit summaries and/or explanations of benefits (EOBs) relevant to the fee dispute, or a statement certifying that the carrier did not receive the provider's disputed billing prior to the request. The Division concludes that the respondent has not met the requirements of §133.307(j)(1)(C).
7. The insurance carrier denied procedure codes 99213 performed March 23, March 29, March 30, April 6, April 7, and April 4, 2005, with reason code 210 – "THE VISIT HAS BEEN INCLUDED IN THE TREATMENT PERFORMED." Per Medicare payment policy, evaluation and management codes may not be reported with physical therapy services performed on the same date unless documentation supports evaluation and management of a new condition, exacerbation or recurrence of the current condition, or for a reassessment midway through treatment. Review of the submitted documentation finds that the health care provider performed physical therapy services on the same day as evaluation and management services. The requestor did not provide documentation to support that the disputed evaluation and management services were related to a new condition, exacerbation or recurrence of the current condition, or for a reassessment midway through treatment. The insurance carrier's denial reason is therefore supported. Reimbursement cannot be recommended for these services.
8. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.202(b), effective January 5, 2003, 27 *Texas Register* 4048 and 12304, which requires that "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." §134.202(c) further 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: (1) 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 97110, service date February 1, 2005, has a Medicare payment rate of \$28.91. This amount multiplied by 2 units is \$57.82. This amount multiplied by 125% results in a MAR of \$72.28. This amount is recommended.
 - Procedure code 99213, service date February 1, 2005, has a Medicare payment rate of \$54.65. This amount multiplied by 125% results in a MAR of \$68.31. This amount is recommended.
 - Procedure code G0283, service date February 1, 2005, has a Medicare payment rate of \$11.72. This amount multiplied by 125% results in a MAR of \$14.65. This amount is recommended.
 - Procedure code 99213, service date February 10, 2005, has a Medicare payment rate of \$54.64. This amount multiplied by 125% results in a MAR of \$68.31. This amount is recommended.
 - Per Medicare payment policy, procedure code 97140, service date March 15, 2005, may not be reported with code 97012 performed on the same date. Reimbursement is not recommended.
 - Per Medicare payment policy, procedure code 97140, service date March 16, 2005, may not be reported with code 97012 performed on the same date. Reimbursement is not recommended.
9. Per 28 Texas Administrative Code §129.5(j), reimbursement for Division specific work status report code 99080-73, service date February 7, 2005, is \$15.00. This amount is recommended.
10. The total recommended payment for the services in dispute is \$238.55. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$238.55.

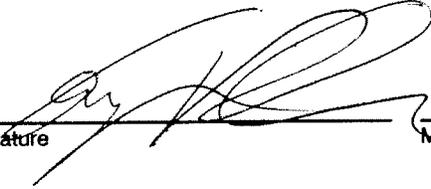
Conclusion

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 \$238.55.

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 \$238.55 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** _____ Date 5/23/14
Medical Fee Dispute Resolution Officer

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.