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
EMPLOYERS MUTUAL CASUALTY COMPANY

MFDR Tracking Number
M4-07-3238-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 18, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DOS 7/10/06 through 8/28/06: The physiotherapy was preauthorized for 2 different periods of time, included please find 2 certification numbers. Carrier elected to make partial payments in some dates of service."

Amount in Dispute: $426.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "These services were reduced in accordance with the applicable fee guidelines as set out in the attached EOB. Certain charges exceeded the authority granted in pre-authorization. Carrier maintains that it has paid all reasonable, necessary and related charges in accordance with the applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 10, 2006 to August 28, 2006	Professional Medical Services	$426.56	$109.01

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out rules for prospective and concurrent review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 15 – PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER.
   - 151 – PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS MANY SERVICES.

- 213 – THE CHARGE EXCEEDS THE SCHEDULED VALUE AND/OR PARAMETERS THAT WOULD APPEAR REASONABLE.
- 932 – NOT AUTHORIZED FOR SERVICE PER UTILIZATION RECOMMENDATION.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

Issues

1. Did the request for Medical Fee Dispute Resolution include a copy of each EOB relevant to the fee dispute?
2. Are the insurance carrier's payment denial reasons supported for dates of service July 18 to August 25, 2006?
3. Are the insurance carrier's payment denial reasons supported for date of service August 28, 2006?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. Former 28 Texas Administrative Code §133.307(c)(2)(B), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, 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 documentation providing evidence of carrier receipt of the request for an EOB." Review of the submitted documentation finds that the request does not include copies of any EOBs for disputed date of service July 10, 2006. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(B) with regards to disputed date of service July 10, 2006. Review of the documentation submitted by the requestor finds insufficient information to support a determination that additional reimbursement is due. Reimbursement cannot be recommended for disputed date of service July 10, 2006.
2. The insurance carrier denied disputed services from July 18, 2006 to August 25, 2006 with reason codes 151 – "PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS MANY SERVICES."; and 213 – "THE CHARGE EXCEEDS THE SCHEDULED VALUE AND/OR PARAMETERS THAT WOULD APPEAR REASONABLE." Review of the submitted clinical notes finds that neither the number of minutes performed nor the start and stop times for the disputed procedures were documented. The notes state that services were performed "as per flow sheet," but no flow sheet was included with the requestor's documentation. The submitted documentation does not support the services as billed. Moreover, per 28 Texas Administrative Code §134.600(c), effective May 2, 2006, 31 *Texas Register* 3566, "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care." Per subsection (p)(5), the non-emergency health care requiring preauthorization includes: "physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning." No documentation was found to support an emergency. Review of the submitted information finds that the disputed services are physical medicine therapeutic procedures, consistent with subsection (p)(5). Documentation supports that the health care provider sought preauthorization of the disputed health care. The insurance carrier's utilization review authorized "three (3) weeks or (9) sessions" to begin within 30 days of June 27, 2006 and an additional "three (3) weeks or (9) sessions" to begin within 30 days of August 2, 2006, for a total of eighteen sessions. Additionally, both NOTICE OF UTILIZATION REVIEW FINDINGS letters specified that "Per CMS guidelines, no more than three different modalities or 60 minutes should be utilized per physical therapy session." Review of the submitted EOBs finds that the insurance carrier reimbursed the health care provider to the approved limits of the authorization for 60 minutes of therapy (four timed units, where each unit is defined as 15 minutes in the description of the procedure code) each day for dates of service July 18, August 23, and August 25, 2006. The insurance carrier's denial reasons are supported. No additional reimbursement is recommended for dates of service July 18, August 23, or August 25, 2006.
3. The insurance carrier denied disputed date of service August 28, 2006 with reason codes 15 – "PAYMENT ADJUSTED BECAUSE THE SUBMITTED AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER."; and 932 – "NOT AUTHORIZED FOR SERVICE PER UTILIZATION RECOMMENDATION." Review of the submitted NOTICE OF UTILIZATION REVIEW FINDINGS letter dated August 2, 2006, finds, as stated above, that the insurance carrier's utilization review authorized "three (3) weeks or (9) sessions" with a stipulation that "This medical necessity determination assumes the services will be initiated within the next 30 days." Review of the notice letter finds no indication of a specific end date to the authorization of services. It is not clear from the language of the notice whether the 30 days is meant to start on the date of review (July 27), the date of verbal notice to the provider (August 1), or the date of the letter (August 2). Nor is it clear whether all services must be completed within the 30 day period or whether

only the first of the nine approved sessions must begin within the specified time frame. Moreover, it is not clear that the assumption on the part of the utilization reviewer that the services will be initiated within the next 30 days is meant to be construed as a plain language notice that the authorization will expire on a certain date. Review of the submitted information finds that the disputed date of service of August 28, 2006 falls within 30 days of both the written and verbal notice dates indicated on the NOTICE OF UTILIZATION REVIEW FINDINGS letter, dated August 2, 2006. No documentation was presented to support that the health care provider had exhausted the number of sessions authorized prior to rendering treatment. The insurance carrier's denial reasons are not supported. Accordingly, reimbursement will be considered per applicable Division rules and fee guidelines for disputed services rendered August 28, 2006.

4. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.202(c) 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: (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%." The disputed service was billed with procedure code 97530. The services were rendered in Tarrant County. The 2006 Medicare payment rate is $29.07. This amount multiplied by 3 units is $87.21. This amount multiplied by 125% results in a MAR of $109.01.
5. The total recommended payment for the services in dispute is $109.01. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $109.01. This amount is recommended.

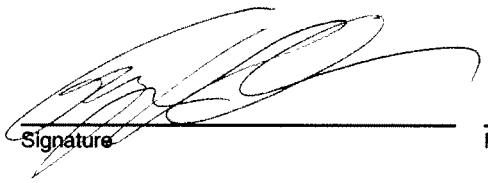
Conclusion

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 $109.01.

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 $109.01 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature



Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

May 23, 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.