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
KULM MEDICAL PA

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-10-1778-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
November 16, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "attached FCE clearly documents six units were performed. . . . Reimbursement shall be for up to a maximum of four hours for the initial test . . . Please note this was the initial and only FCE performed on this patient."

Amount in Dispute: $193.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed CPT code 97750 . . . Texas Mutual paid two units of a physical performance test for this. . . . The requestor changed the billing codes on the bill by adding the modifier FC. Because the modifier materially changes the amount of reimbursement, Texas Mutual considered this to be a new bill. However, this bill was received 9/21/09, well past the 95 days for timely bill submission."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 27, 2009	Functional Capacity Evaluation	$193.50	$193.50

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 §134.203 sets out the fee guidelines for professional medical services.
2. Texas Administrative Code §134.204 sets out fee guidelines for Workers' Compensation specific services.
3. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
4. 28 Texas Administrative Code §133.210 sets out documentation requirements.
5. 28 Texas Administrative Code §133.250 sets out procedures for requesting reconsideration of a medical bill.
6. Texas Labor Code §408.0272 provides certain exceptions to untimely claim submission by health care providers.
7. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.

8. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
9. 28 Texas Administrative Code §19.2003 defines words and terms pertaining to utilization review of health care.
10. 28 Texas Administrative Code §19.2015 sets out procedures for the retrospective review of medical necessity.
11. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
    - 4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
    - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
    - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
    - 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT. THIS CHANGE TO BE EFFECTIVE 6/1/07: CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. (USE GROUP CODES PR OR CO DEPENDING UPON LIABILITY)
    - 57 – PAYMENT DENIED/REDUCED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE, THIS MANY SERVICES, THIS LENGTH OF SERVICE, THIS DOSAGE, OR THIS DAY'S SUPPLY.
    - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
    - 731 – 134.801 & 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN T HE 95TH-DAY AFTER THE DATE OF SERVICE, FOR SERVICE ON OR AFTER 9/1/05
    - 732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. SERVICES ARE NOT REIMBURSABLE AS BILLED. CPT AND/OR MODIFIER BILLED INCORRECTLY.
    - 793 – REDUCTION DUE TO PPO CONTRACT. PPO CONTRACT WAS APPLIED BY FOCUS. FOR PROVIDER SUPPORT 1-800-243-2336.
    - 863 – DOCUMENTATION DOES NOT SUPPORT THE NEED FOR MORE THAN 30 MINUTES OF TIME.
    - 891 – THE INSURANCE COMPANY IS REDUCING OR DENYING PAYMENT AFTER RECONSIDERATION.

Issues

1. Were the services timely submitted to the insurance carrier for consideration of payment?
2. Are the disputed services subject to a contracted fee arrangement?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason codes 731 – "134.801 & 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN T HE 95TH-DAY AFTER THE DATE OF SERVICE, FOR SERVICE ON OR AFTER 9/1/05"; and 29 – "THE TIME LIMIT FOR FILING HAS EXPIRED." 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." The respondent asserts that "The requestor changed the billing codes on the bill by adding the modifier FC. Because the modifier materially changes the amount of reimbursement, Texas Mutual considered this to be a new bill. However, this bill was received 9/21/09, well past the 95 days for timely bill submission." Review of the submitted documentation finds that the insurance carrier received the initial bill within 95 days from the date of service.

   28 Texas Administrative Code §133.20(g) states that "Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier." Review of the submitted documentation finds that the insurance carrier did not return the bill as an incomplete bill but rather processed the bill and issued payment. The Division finds that the initial bill was therefore a complete bill. Accordingly, §133.20(g) does not apply to the second bill submission.

   Per 28 Texas Administrative Code §133.250(a), "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action." The health care provider did so; the Division therefore concludes that the second bill submission was not a new bill but rather a request for reconsideration.

   In the request for reconsideration, the provider appended modifier -FC to disputed procedure code 97750. The Division has state in the adoption preamble to rule 133.250 (31 *Texas Register* 3551) that "A reconsideration request may include corrections relating to modifiers and/or number of units. For this reason, a request for reconsideration may include changes in the number of units or modifiers from that in the original bill for proper processing and payment of the bill." The insurance carrier's argument that the appended modifier rendered the request for reconsideration a new bill (and thus subject to the timely filing rule) is not supported. The Division finds that the services in dispute were timely submitted to the insurance carrier for

consideration of payment. The insurance carrier's denial reason is not supported. The services will therefore be reviewed per applicable Division rules and fee guidelines.

2. The insurance carrier denied disputed services with reason codes 45 – "CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT. THIS CHANGE TO BE EFFECTIVE 6/1/07: CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. (USE GROUP CODES PR OR CO DEPENDING UPON LIABILITY)"; and 793 – "REDUCTION DUE TO PPO CONTRACT. PPO CONTRACT WAS APPLIED BY FOCUS. FOR PROVIDER SUPPORT 1-800-243-2336." No documentation was found to support a contracted fee arrangement between the parties to this dispute. Nevertheless, on January 11, 2011, the Division requested the respondent to provide documentation to support the contractual payment reductions in accordance with Labor Code Sec. 413.011(d-3) and (d-1)(2), as well as 28 Texas Administrative Code §133.4 regarding notice to the provider that the insurance carrier had been granted access to the health care provider's contract with the alleged network. No further information was submitted by the respondent.

   Labor Code Sec. 413.011(d-1) requires that:

   > If a carrier or the carrier's authorized agent chooses to use an informal or voluntary network to obtain a contractual fee arrangement, there must be a contractual arrangement between:
   >
   > (1) the carrier or authorized agent and the informal or voluntary network that authorizes the network to contract with health care providers on the carrier's behalf; and
   >
   > (2) the informal or voluntary network and the health care provider that includes a specific fee schedule and complies with the notice requirements established under Subsection (d-2).

   Labor Code Sec. 413.011(d-2) requires that

   > "An informal or voluntary network, or the carrier or the carrier's authorized agent, as appropriate, shall notify each health care provider of any person that is given access to the network's fee arrangements with that health care provider within the time and according to the manner provided by commissioner rule."

   Labor Code Sec. 413.011(d-3) states, in pertinent part, that:

   > An insurance carrier shall provide copies of each contract described by Subsection (d-1) to the division on the request of the division. . . . Notwithstanding Subsection (d-1) or Section 1305.153, Insurance Code, the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract: . . .
   >
   > (3) does not:
   >
   > (A) clearly state that the contractual fee arrangement is between the health care provider and the named insurance carrier or the named insurance carrier's authorized agent; or
   >
   > (B) comply with the notice requirements under Subsection (d-2).

   28 Texas Administrative Code §133.4(c) further requires that:

   > Required Notice. Each informal network or voluntary network, or the insurance carrier, or the insurance carrier's authorized agent, as appropriate, shall notify each affected health care provider of any person that is given access to the informal or voluntary network's fee arrangement with that health care provider within the time and manner provided by this section.

   28 Texas Administrative Code §133.4(g) states that:

   > The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:
   >
   > (1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or
   >
   > (2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115.

   Review of the submitted information finds no documentation to support a contractual arrangement between the carrier or authorized agent and the alleged informal or voluntary network that authorizes the network to contract with health care providers on the carrier's (Texas Mutual's) behalf in accordance with Subsection (d-1)(1). No documentation was found to support notice to the health care provider that Texas Mutual had been given access to the network's fee arrangements with the health care provider in accordance with Labor Code 413.011(d), Subsections (d-2), (d-1)(2), and (d-3)(3)(B), or 28 Texas Administrative Code §133.4. Review of the submitted information finds no documentation that clearly states that the contractual fee arrangement is between the health care provider and the named insurance carrier (Texas Mutual) or the named insurance carrier's authorized agent in accordance with Subsection (d-3)(3)(A). The Division therefore finds that the insurance carrier's payment reduction reason is not supported. Consequently, the Division concludes that the insurance carrier is not entitled to pay the health care provider at a contracted fee negotiated by an informal or voluntary network. The insurance carrier may not pay fees that are inconsistent with the Division's fee guidelines. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

3. The insurance carrier denied disputed services with reason codes 16 – "CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)"; 57 – "PAYMENT DENIED/REDUCED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE, THIS MANY SERVICES, THIS LENGTH OF SERVICE, THIS DOSAGE, OR THIS DAY'S SUPPLY."; and 225 – "THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION." Review of the submitted information finds that the documentation supports the services as billed. Moreover, the procedure for an insurance carrier to request documentation not otherwise required upon submission of a bill is specified in §133.210(d) as follows:

   Any request by the insurance carrier for additional documentation to process a medical bill shall:
   (1) be in writing;
   (2) be specific to the bill or the bill's related episode of care;
   (3) describe with specificity the clinical and other information to be included in the response;
   (4) be relevant and necessary for the resolution of the bill;
   (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
   (6) indicate the specific reason for which the insurance carrier is requesting the information; and
   (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.

   Review of the submitted information finds no documentation to support that the insurance carrier made an appropriate request for additional documentation with the specificity required by §133.210(d). The Division concludes that the insurance carrier failed to meet the requirements of §133.210(d). Accordingly, these denial reasons are not supported.

4. The insurance carrier denied disputed services with reason code 863 – "DOCUMENTATION DOES NOT SUPPORT THE NEED FOR MORE THAN 30 MINUTES OF TIME." Former 28 Texas Administrative Code §19.2003(28), effective June 1, 2003, 28 *Texas Register* 3965 defines retrospective review as "The process of reviewing health care which has been provided to injured employees under the Texas Workers' Compensation Act to determine if the health care was medically reasonable and necessary." Former 28 Texas Administrative Code §19.2015, effective June 1, 2003, 28 *Texas Register* 3965, requires that:

   (a) When a retrospective review is performed:

      (1) such retrospective review shall be based on written screening criteria as defined in §19.2003 of this title (relating to Definitions) established and periodically updated, at a minimum, upon certification renewal with appropriate involvement from doctors, including doctors engaged in an active practice, and other health care providers; and

      (2) such retrospective review shall be under the direction of a physician and performed in accordance with Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers).

   (b) When retrospective review results in an adverse determination or denial of payment, the utilization review agent shall notify the health care providers of the opportunity to appeal the determination through the appeal process as outlined in Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers).

   No documentation was found to support that the insurance carrier followed the appropriate administrative process required for making determinations regarding the medical necessity of the disputed services. Consequently, the Division finds that the insurance carrier has not met the requirements of §19.2015. The Division therefore concludes that this denial reason is not supported.

5. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(g) which states, in pertinent part, that "FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test." 28 Texas Administrative Code §134.203(c), requires that "To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) 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 $52.83 . . . (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." The applicable Division conversion factor for calendar year 2009 is $53.68. Reimbursement is calculated as follows:

- The healthcare provider billed procedure code 97750-FC, date of service January 27, 2009, performed in Garland, Texas, located in Dallas County, for six units. Review of the submitted documentation finds that six units are supported. The Medicare rate for procedure code 97750 is $29.09 per unit. This amount divided by the Medicare conversion factor of 36.0666 and multiplied by the Division's 2009 conversion factor of $53.68 is $43.30. This amount multiplied by six units results in a MAR of $259.80.

6. The total recommended payment for the services in dispute is $259.80. The insurance carrier has previously paid $64.50. The requestor is seeking $193.50. 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 $193.50.

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 $193.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	November 25, 2014
Signature	Medical Fee Dispute Resolution Officer	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.