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
ANGELINA REHABILITATION CENTER

Respondent Name
AMERICAN HOME ASSURANCE CO

MFDR Tracking Number
M4-10-3485-02

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 1, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim for date of service, October 28, 2009 has been denied to [sic] reason code 1 as explained on the EOB. Our facility has contacted AIG – Chartis for explanation for denial, [sic] since we have authorization on file for [injured worker] to be treated for physical therapy. Their office has advice [sic] us to contact MedRisk for payment for the date of service October 28, 2009. Claim has been sent to MedRisk and was denied."

Amount in Dispute: $166.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Your request for reconsideration is being returned to you. The bill has been reviewed twice indicating our position remains the same. Attached you will find the previous EOR. If you disagree with our decision please contact the DWC Medical Dispute Resolution."

Response Submitted by: Chartis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 28, 2009	97032-GP, 97035-GP, 97110-GP x 3 units and 97140-GP	$166.76	$166.76

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 §133.203 sets out the fee guideline for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – Charges exceed your contracted/legislated fee arrangement

Issues

1. Did the insurance carrier submit documentation to support the contract reduction denial?
2. Did the requestor bill in conflict with the NCCI edits?
3. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds that the insurance carrier reduced disputed services with reason code "45 – Charges exceed your contracted/legislated fee arrangement." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on September 29, 2010 the Division requested the respondent to provide a copy of the referenced contract as well as a documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement.

   Review of the submitted information finds that the documentation does not support the denial of "45 – Charges exceed your contracted/legislated fee arrangement", as a result, the disputed services will be reviewed for payment pursuant to the applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The division completed NCCI edits to identify edit conflicts that could potentially affect reimbursement. The following was identified:

   The requestor billed CPT codes 97032-GP, 97035-GP, 97110-GP, and 97140-GP rendered on October 28, 2009. The division did not identify NCCI edits conflicts that would affect reimbursement. Therefore the disputed services are reviewed pursuant to 28 Texas Administrative Code §134.203 (c).
3. Per 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. (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. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (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."

   Per 28 Texas Administrative Code §134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   The MAR reimbursement for CPT code 97032-GP is $22.95, the requestor seeks $19.52, therefore this amount is recommended.

   The MAR reimbursement for CPT code 97035-GP is $16.56, the requestor seeks $14.08, therefore this amount is recommended.

   The MAR reimbursement for CPT code 97110-GP is $119.79, the requestor seeks $101.82, therefore this amount is recommended.

   The MAR reimbursement for CPT code 97140-GP is $36.86, the requestor seeks $31.34, therefore this amount is recommended.

   Review of the submitted documentation finds that the requestor is entitled to a total reimbursement of $166.76.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $166.76.

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 $166.76 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		August 8, 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.