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
SAN ANTONIO SPINE AND REHAB

Respondent Name
ACCIDENT FUND NATIONAL INSURANCE

MFDR Tracking Number
M4-11-1126-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
NOVEMBER 29, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 08/23/201 preauthorization for CPT codes 97110-4units, G0283-1unit and 97140-joint mobilization were authorized as requested."

Amount in Dispute: $79.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2010	CPT Code 97140-GP (X2)	$79.32	$78.52

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 §134.203 effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific treatments and services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 168-Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services.
   - 119-Benefit maximum for this time period or occurrence has been reached.
   - 247-A payment or denial has already been recommended for this service.
   - 18-Duplicate claim/service.

Issues

1. Did the requestor exceed the daily maximum allowance for physical therapy/physical medicine services?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for code 97140-GP based upon reason codes "168 and 119."

   The requestor contends that reimbursement is due because "On 08/23/201 preauthorization for CPT codes 97110-4units, G0283-1unit and 97140-joint mobilization were authorized as requested."

   28 Texas Administrative Code §134.600(l) states "The carrier shall not withdraw a preauthorization or concurrent review approval once issued. The approval shall include:

   (1) the specific health care;
   (2) the approved number of health care treatments and specific period of time to complete the treatments; and
   (3) a notice of any unresolved dispute regarding the denial of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury."

   A review of the preauthorization report finds that the respondent gave preauthorization approval for "Aquatic Therapy x12 left knee 97113 97140…12 Visit(s)." The Division finds that the respondent did not limit the number of units of 97140 on the preauthorization report; therefore, the respondent's denial based upon reason codes "168 and 119" is not supported.

2. Per 28 Texas Administrative Code §134.203(c)(1)(2), "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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2010 DWC conversion factor for this service is 54.32.

   The Medicare Conversion Factor is 36.8729

   Review of Box 32 on the CMS-1500 the services were rendered in San Antonio, Texas; therefore, the Medicare participating amount is based upon the locality of "Rest of Texas".

   Using the above formula the Division finds:

Code	Medicare Participating Amount	MAR	Amount Paid	Amount Due
97140	$26.65	$39.26 X 2 = $78.52	$0.00	$78.52

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 $78.52.

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 $78.52 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

.

Authorized Signature

		06/18/2014
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.