



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

FONDREN ORTHOPEDIC GROUP, L.L.P.

Respondent Name

NORTH FOREST ISD

MFDR Tracking Number

M4-11-2262-01

Carrier's Austin Representative

Box Number 21

MFDR Date Received

MARCH 7, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The contract w/Rockport has a flat rate for 97110 of 37.42 X 3 units totals 112.26 not paid per fee schedule this claim was submitted several times and even to the adjuster someone should of recv'd this and concerned this for payment."

Amount in Dispute: \$159.48

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
May 24, 2010	CPT Code 97140-GP Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	\$5.97	\$5.97
May 24, 2010 August 2, 2010 August 9, 2010	CPT Code 97110 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	\$1.64 \$149.68 \$2.19	\$3.83
TOTAL		\$159.48	\$9.80

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, effective May 25, 2008, sets out the procedures for resolving a medical fee dispute.

2. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
3. 28 Texas Administrative Code §102.4(h) effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. 28 Texas Administrative Code §134.203 effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
5. 28 Texas Administrative Code §133.4, effective July 27, 2008, requires the insurance carrier to notify providers of contractual agreements for informal and voluntary networks.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
 - W1-Workers compensation rate fee schedule adjustment.
 - B5-Based on fee schedule guidelines, bills submitted after the 95th day after the date of service are disallowed.
 - B5-Payment adjusted because coverage/program guidelines were not met or were exceeded.
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 113-001-Network import re-pricing-Contracted provider
 - 113-022-Export/import re-pricing explanation 2: 015 Rockport Healthcare Grp
 - 332-The reimbursement has been calculated according to the fee schedule guidelines for the provider.
 - 663-Reimbursement has been calculated according to the state fee schedule guidelines.
 - 900-Based on further review, no additional allowance is warranted.
7. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on March 22, 2011. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Does a contractual agreement issue exist in this dispute?
2. Does a timely filing issue exist for physical therapy services rendered on August 2, 2010?
3. Is the requestor entitled to additional reimbursement for CPT code 97140-GP and 97110-GP?

Findings

1. According to the explanation of benefits, the respondent reduced payment for CPT codes 97140-GP and 97110-GP based upon a contractual agreement.

28 Texas Administrative Code §133.4(g) states "Noncompliance. 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."

A review of the submitted documentation finds that the respondent did not submit any documentation to support that a contractual agreement exists between the parties and that the provider was notified in accordance with Labor Code §413.011.

28 Texas Administrative Code §133.4(h) states "Application of Division Fee Guideline. If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1) of this title (relating to Medical Reimbursement), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3) of this title."

The Division concludes that the respondent's is not entitled to pay the requestor at a contracted fee reduction;

therefore, the disputed services will be reviewed per applicable Division rules and guidelines.

2. The respondent denied reimbursement for CPT code 97110 rendered on August 2, 2010 based upon timely filing claim, reason code "B5."

Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

28 Texas Administrative Code §102.4(h), states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:

- (1) the date received, if sent by fax, personal delivery or electronic transmission or,
- (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

The requestor submitted facsimile reports that indicate the disputed bill was sent on December 29, 2010 and February 15, 2011. The explanation of benefits, indicates that the bill was sent on January 3, 2011. All of these dates are past the 95 day deadline set out in Texas Labor Code §408.027(a); therefore, the Division finds that the requestor failed to support that the disputed bill for August 2, 2010 was submitted timely to the insurance carrier. As a result, no reimbursement is recommended.

3. 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 Humble, Texas; therefore, the Medicare participating amount is based upon the locality of "Houston, Texas".

Using the above formula the Division finds:

Code	Medicare Participating Amount	MAR or lesser amount requested by Requestor	Amount Paid	Amount Due
97140	\$27.60	\$40.66, Requestor is seeking \$40.53	\$34.56	\$5.97
97110	\$29.45	\$43.38, Requestor is seeking \$37.42 X 7 units = \$261.94	\$258.11	\$3.83

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 \$9.80.

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 \$9.80 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		06/23/2014
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.