



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

CURNYN PHYSICAL THERAPY

Respondent Name

LIBERTY INSURANCE CORP

MFDR Tracking Number

M4-12-0438-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

OCTOBER 11, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have had correspondence with Medrisk and Liberty Mutual regarding the above mentioned claim and have been unable to obtain payment for physical therapy services that we provided. I am including the dates of service on a list along with HICFA's, EOB's (some showing payment, some not), as well as the letter we received authorizing treatment."

Amount in Dispute: \$245.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have no record of having received a request for reconsideration for the 2010 services. These services were billed by the provider to MedRisk according to their contract. Our reimbursement was made to MedRisk who in turn reimbursed the provider according to the provisions of their contract to which we do not have access. The contract was applicable to charges prior to 1/1/2011. After that date, the MedRisk contract would only be applicable to network claims. This is not a network claim under the Liberty HCN. For dates of service 1/21/11 and 1/28/11 the provider billed MedRisk. After 1/1/2011 we are not allowed PPO reductions. Only Certified HCN reductions are allowed. Since this is not a HCN claim, the provider must bill Liberty Mutual directly. The provider has not billed Liberty Mutual for these services."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 10, 2010	CPT Code 97001 Physical Therapy Evaluation	\$70.00	\$70.00
December 17, 2010 December 20, 2010 December 23, 2010 December 28, 2010	CPT Code 97530 (X2) Therapeutic Activities	\$12.39 \$12.39 \$5.20 \$5.20	\$35.18
January 21, 2011 January 28, 2011	CPT Code 97530 (X2) Therapeutic Activities	\$70.00 \$70.00	\$140.00
TOTAL		\$245.18	\$245.18

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 set out the fee guideline for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - PPN-Day Rate or Fee Schedule Met.
 - XX20-Under Texas Insurance Code Chapter 1305, Informal and Voluntary networks are required to be certified as a Workers' Compensation Health Care Network (HCN). The servicing provided should submit bills directly to.
 - M463-Payment has met the maximum allowance for multiple services.
 - P303-This service was reviewed in accordance with your contract.
 - 24-Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
 - 17-Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.
 - W1-Workers Compensation State Fee Schedule Adjustment.

Issues

1. Does the submitted documentation support that a contractual agreement exists between the parties in this dispute?
2. Does the submitted documentation support billing CPT code 97001?
3. Is the requestor entitled to reimbursement?

Findings

1. According to the submitted explanations of benefits, the insurance carrier reduced or denied disputed services with reason codes "24-Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan," and "P303-This service was reviewed in accordance with your contract."

The respondent contends that "These services were billed by the provider to MedRisk according to their contract. Our reimbursement was made to MedRisk who in turn reimbursed the provider according to the provisions of their contract to which we do not have access. The contract was applicable to charges prior to 1/1/2011. After that date, the MedRisk contract would only be applicable to network claims. This is not a network claim under the Liberty HCN."

Based upon the respondent's position, the Division is to presume that a contract existed between Liberty Mutual and MedRisk to process the requestor's claims for dates of service prior to 1/1/2011, and that after this date the requestor was to bill Liberty Mutual directly. A review of the submitted documentation finds that the respondent did not submit any copies of contractual agreements or documentation to support this contract, nor that the provider was notified that this contract was terminating and that the requestor must bill the respondent directly. For these reasons, the Division finds that the respondent has not supported the above denial/reduction explanations; therefore, the disputed services will be reviewed for payment in accordance with applicable Division fee guidelines.

2. According to the submitted explanation of benefits, the respondent denied reimbursement for the initial physical therapy evaluation, CPT code 97001, based upon reason codes "W1-Workers Compensation State Fee Schedule Adjustment," and "17-Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate." A review of the submitted documentation finds a copy of the December 10, 2010 initial evaluation report; therefore, the respondent's denial of reimbursement is not supported.
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 and 2011 DWC conversion factor for this service is 54.32 and 54.54, respectively.

The Medicare Conversion Factor is 36.8729 for 2010 and 33.9764 for 2011.

Review of Box 32 on the CMS-1500 the services were rendered in Fort Worth, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Fort Worth, Texas.

Using the above formula, the Division finds the following:

2010:

Code	Medicare Participating Amount	Maximum Allowable Reimbursement	Total Amount Paid	Total Amount Due
97001	\$71.82	\$105.80, requestor is seeking \$70.00	\$0.00	\$70.00
97530 (X2)	\$31.04	\$45.73 X 2 = \$91.46, requestor is seeking \$70.00 X 4 dates = \$280.00	\$244.82	\$35.18

2011

Code	Medicare Participating Amount	Maximum Allowable Reimbursement	Total Amount Paid	Total Amount Due
97530 (X2)	\$31.96	\$51.30 X 2 = \$102.60 X 2 dates = \$205.20, the requestor is seeking \$140.00.	\$0.00	\$140.00
TOTAL DUE				\$245.18

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 \$245.18.

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 \$245.18 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

08/15/2014
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.