



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

Caba Therapy Services

Respondent Name

Texas Mutual

MFDR Tracking Number

M4-14-1922-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

February 28, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have received partial payment on the disputed claims that have been sent to Texas Dept of Ins Workers Comp Division. The dates of service submitted were 9/3/13, 9/9/13, 9/11/13 and 9/16/13 and only 9/9/13 and 9/16/13 have been paid. Please pay the dates of service 9/3/13 (\$170) and 9/11/13 (\$197) to avoid further action with Texas Dept of Ins W/C Division."

Amount in Dispute: \$723.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In order to resolve this fee reimbursement dispute Texas Mutual Insurance Company has elected to pay the disputed services."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 3, 2013 September 11, 2013	Physical Therapy	\$723.00	\$224.98

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 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care providers.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 29 – The time limit for filing has expired
 - 193 – Original payment decision is being maintained

Issues

1. Did the requestor support timely submission of services in dispute?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the services in dispute as, 29 “The time limit for filing has expired.” Per 28 Texas Administrative Code §133.20(a) “The health care provider shall submit all medical bills to the insurance carrier except when billing the employer in accordance with subsection (j) of this section.(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.” Review of the submitted documentation finds an electronic claims submission report from Availity dated September 12, 2013 for unpaid dates of service 9/3/2011 and 9/22/2011. The carrier’s denial is not supported. Therefore, the disputed services will be reviewed per applicable rules and fee guidelines.
2. 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 (date of service yearly conversion factor).The Maximum Allowable Reimbursement (MAR) is calculated as follows:
 - Procedure code 97110, service date September 3, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.45. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 0.912 is 0.43776. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.809 is 0.00809. The sum of 0.89585 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$49.54. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at \$49.54. The PE reduced rate is \$37.44. The total is \$86.98.
 - Procedure code G0283, service date September 3, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.18 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.18. The practice expense (PE) RVU of 0.21 multiplied by the PE GPCI of 0.912 is 0.19152. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.809 is 0.00809. The sum of 0.37961 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$20.99. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is \$15.70.
 - Procedure code 97010, service date September 3, 2013, has a status indicator of B, which denotes a bundled code. Payments for these services are always bundled into payment for other services to which they are incident. No payment can be recommended.
 - Procedure code 97110, service date September 11, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.45. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 0.912 is 0.43776. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.809 is 0.00809. The sum of 0.89585 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$49.54. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at \$49.54. The PE reduced rate is \$37.44. The total is \$86.98.
 - Procedure code 97140, service date September 11, 2013, represents a professional service with

reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.43. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.912 is 0.40128. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.809 is 0.00809. The sum of 0.83937 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$46.42. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 50% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is \$35.32.

- Procedure code 97010, service date September 11, 2013, has a status indicator of B, which denotes a bundled code. Payments for these services are always bundled into payment for other services to which they are incident. No payment can be recommended.
3. The total allowable reimbursement for the services in dispute is \$224.98. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$224.98. 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 \$224.98.

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 \$224.98 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

September 9, 2014

Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.