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 and Address

DS SCHMIDT DC MSN NP C
SUITE 107
7125 MARVIN D LOVE FREEWAY
DALLAS TX 75237

Respondent Name
PROTECTIVE INSURANCE CO

Carrier's Austin Representative
Box Number 17

MFDR Tracking Number
M4-14-0036-01

MFDR Date Received
September 4, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We obtained preauthorization for physical therapy. The carrier denied payment for date of service 10/23/12, using ANSI Code 216, Based on findings of a review organization. We submitted a Request for Reconsideration with our documentation showing the services were preauthorized."

Amount in Dispute: $394.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request. A copy of the DWC060 was placed in the carrier representative box 17 assigned to Downs Stanford PC. Downs & Stanford stamped received on September 12, 2013. A findings and decision will be issued based on the documentation continued in the dispute at the time of the audit.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 23, 2012	97110-GP, 97530-GP	$394.92	$394.92

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 a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedures for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 216 – Based on findings of a review organization
   - GP – Service delivered under OP PT care plan

Issues

1. Did the requestor obtain preauthorization for the disputed charges?
2. Did the requestor bill in conflict with the NCCI edits?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning."

   Review of the submitted documentation (preauthorization letter) issued by Corvel, dated October 15, 2012 states in pertinent part, "Determination: Approved reduce to 2 PT 97110 97530 to complete by 12-7-12."

   Review of the submitted documentation (CMS-1500 and medical documentation) support that the requestor provided CPT code 97110 and 97530, as a result reimbursement is recommended per 28 Texas Administrative Code §134.203.
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."

   Review of the submitted documentation supports that the requestor billed for CPT code 97110 and 97530 on October 23, 2012. The division conducted an NCCI edit to identify edit conflicts that would potentially affect reimbursement. No NCCI edit conflicts were identified, therefore, the division will determine reimbursement 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." Review of the submitted documentation finds that reimbursement for the following CPT codes is as follows:

   The MAR reimbursement for CPT code 97110 is $30.97 x 4 units = $199.66, the requestor seeks reimbursement in the amount of $188.56, therefore this amount is recommended.

   The MAR reimbursement for CPT code 97530 is $ 34.09 x 4 units = $219.78, the requestor seeks reimbursement in the amount of $206.36, therefore 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 $394.92.

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 $394.92 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	January 23, 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).