



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

ELITE HEALTHCARE FORT WORTH

Respondent Name

ACCIDENT FUND INSURANCE CO

MFDR Tracking Number

M4-14-0843-01

Carrier's Austin Representative

Box Number: 06

MFDR Date Received

NOVEMBER 15, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated in a letter dated November 11, 2013: "Patient has authorization for therapy. I have sent in reconsideration for the remainder of partial pays for these dates of service. Carrier will not pay for full therapy according to the authorization we have. All other claims have been paid for in full. This is an approved case..."

Amount in Dispute: \$1,192.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Billed amounts for service code 97110 were reevaluated, and it was determined that the previous amounts paid were correct and Reuestor is not entitled to additional payment."

Response Submitted by: STONE, LOUGHLIN & SWANSON, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 9, 2013 through July 24, 2013	CPT Code 97140	\$1,192.68	\$0.00
July 9, 2013 through July 24, 2013	CPT Code 97110		\$304.20

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 §134.203 sets out the guidelines for medical fee reimbursement.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 1014 – The attached billing has been re-evaluated at the request for the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
 - 193 – Original [sic] payment decision is being maintained. This claim was processed properly the first time.
 - 119 – Benefit maximum for this time period or occurrence has been reached.

- 168 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services.

Issues

1. Did the respondent reimburse the requestor after the request for medical fee dispute resolution.
2. Did the requestor bill according to the fee guideline?
3. Is the requestor entitled to reimbursement?

Findings

1. Review of the insurance carrier's response to the request for medical fee dispute resolution finds that the carrier made additional payment for CPT Code 97140. This was confirmed by the requestor in an e-mail dated June 5, 2014. Therefore, CPT Code 97140 has been reimbursed and is no longer in dispute. The requestor states that a total of \$821.28 is still in dispute for CPT Code 97110.
2. The respondent denied the services using denial codes 168 – “Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services” and 119 – “Benefit maximum for this time period or occurrence has been reached.” Review of the respondents documentation finds that the denials are not supported. The requestor submitted documentation to support preauthorization was approved on June 26, 2013; the requested and approved treatment was “Physical Therapy 3xWk x 3 Wks Right Foot 97110, 97112, 97140.” Therefore, CPT code 97110 will be reviewed in accordance with 28 Texas Administrative Code §134.203(b).
 - Procedure code 97110, service date July 9, 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 0.979 is 0.46992. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.92818 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$51.33. 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 reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$38.34 at 4 units is \$153.36. The respondent reimbursed the requestor \$102.66, therefore, reimbursement in the amount of \$50.70 is recommended.
 - Procedure code 97110, service date July 10, 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 0.979 is 0.46992. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.92818 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$51.33. 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 reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$38.34 at 4 units is \$153.36. The respondent reimbursed the requestor \$102.66, therefore, reimbursement in the amount of \$50.70 is recommended.
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- Procedure code 97110, service date July 22, 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 0.979 is 0.46992. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.92818 is multiplied by the Division conversion factor of \$55.30 for a MAR of \$51.33. 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 reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$38.34 at 4 units is \$153.36. The respondent reimbursed the requestor \$102.66, therefore, reimbursement in the amount of \$50.70 is recommended.
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3. Review of the submitted documentation finds that reimbursement in the amount of \$304.20 (\$50.70 x 6 dates of service) is due.

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 \$304.20.

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 \$304.20 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

June 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).

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