



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

Respondent Name

TPS Joint Self INS Funds

MFDR Tracking Number

M4-14-1151-01

Carrier's Austin Representative

Box Number 11

MFDR Date Received

December 23, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please see the attached response from the carrier in regards to the above docket#. They are going to pay, HOWEVER, are not paying the correct price per the 2013 Fee Schedule... Please leave this MFDR OPEN until 100% paid."

Amount in Dispute: \$1,343.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation an additional recommendation is being made in the amount of \$1,236.19."

Response Submitted by: Injury Management Organization, Inc. 10235 West Little York Road, Suite 265, Houston, TX 77040

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 14, 2013	97140		
June 17, 2013	99213, 97140, 97112		
October 21, 2013	97545, 97546	\$1,343.24	\$0.00
October 22, 2013	97545, 97546		

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 §134.204 sets out fee guidelines for workers' compensation specific services.
- 28 Texas Administrative Code §134.203 sets our reimbursement guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 276 – Time requirements for this CPT# were not met
 - W1 – Workers Compensation Jurisdictional Fee Schedule Adjustment
 - 362 – Modifier – GP Services delivered under an outpatient physical therapy plan of care.
 - 150 – PT time parameters on fee schedule allowance exceeded

- 119 – Benefit maximum for the time period or occurrence has been reached
- 193 – Original payment/decision is being maintained.

Issues

1. What is the applicable rule determining Maximum Allowable Reimbursement?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier used explanation, “Charge exceeds Fee Schedule allowance”. 28 Texas Administrative Code §134.203(c)(1) states in pertinent part, “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 conversion factor)”. The maximum allowable reimbursement is found below:
 Also Texas Administrative Code 134.204 states in pertinent part (h) “The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier.
 (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR.
 (3) For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.
 (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.
 (B) Reimbursement shall be \$64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.”

Date of Service	Submitted Code	Units	MAR	Amount Paid
06/14/2013	97140	2	Division of workman's compensation conversion factor / Medicare Conversion Factor x Non-Facility Price or $(55.3 / 34.023) \times 28.82 = \$46.84 \times 2 \text{ units} = \93.68	\$92.84
06/17/2013	99213	1	$(55.3 / 34.023) \times 69.61 = \113.14	\$112.25
06/17/2013	97140	2	$(55.3 / 34.023) \times 28.82 = \$46.84 \times 2 \text{ units} = \93.68	\$92.84
06/17/2013	97112	2	$55.3 / 34.023 \times 32.16 = \$52.27 \times 2 \text{ units} = \104.54	\$103.12
10/21/2013	97545	1	$\$64 @ 80\% = 51.20 \times 1 \text{ unit} = \51.20	102.40
10/21/2013	97546	6	$\$64 @ 80\% = 51.20 \times 6 \text{ units} = \307.20	\$307.20
10/22/2013	97545	1	$\$64 @ 80\% = 51.20 \times 1 \text{ unit} = \51.20	\$102.40
10/22/2013	97546	6	$\$64 @ 80\% = 51.20 \times 6 \text{ units} = \307.20	\$307.20
		Total	\$1,121.84	\$1,220.25

2. The total allowed amount of the services in dispute is \$1,121.84. The carrier made a payment in the amount of \$1,220.25. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

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Medical Fee Dispute Resolution Officer

June 30, 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.