



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

Praetorian Insurance Co

MFDR Tracking Number

M4-14-2752-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

May 8, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is not a duplicate claim/service. Patient has authorization for 9 visits of physical therapy."

Amount in Dispute: \$408.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 16 – 17, 2013	Physical Therapy	\$408.42	\$166.35

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 §133.200 sets out the procedures for insurance carriers upon receipt of medical bills.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 11 – (112) Service not furnished directly to the patient and/or not documented

Issues

- Did the requestor support the services submitted on medical claim?
- What is the rule that pertains to fee calculations?
- Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on May 15, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
2. The carrier denied the services in dispute as 11 – (112) "Service not furnished directly to the patient and/or not documented." Per 28 Texas Administrative Code §133.210(a) Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results and (b) When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form ...” Review of the submitted medial record finds;
 - a. Manual Therapy (97140), 2 units. No notes were found to support the services performed as billed
 - b. Neuro Re-Ed (97112), 2 units. No notes were found to support the services performed as billed
 - c. Ther. Exercise (97110), 4 units. Submitted record documents; Treadmill (10), Bicycle (15), Lifting Station (20), Proprioception (25), Stretching (20). Supporting documentation was found. This service will be reviewed per applicable rules and fee guidelines.
3. 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).
 - Procedure code 97110, service date December 16, 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 subject to 50% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at \$51.33. The PE reduced rate is \$38.34 at 3 units is \$115.02. The total is \$166.35.
4. The total allowable reimbursement for the services in dispute from which documentation was found to support the level of service is \$166.35. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$166.35. 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 \$166.35.

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 \$166.35 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

December , 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.