



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 South Dallas

Respondent Name

Hartford Insurance Company

MFDR Tracking Number

M4-14-2898-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

May 19, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have received denials for approved physical therapy for the following dates of services: 8/2/13, 8/12/13, 8/14/13, 10/29/13, and 11/12/13. These sessions were all authorized therapy. ...I have also received a partial payment for the team conference done on 11/5/13."

Amount in Dispute: \$1,114.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Hartford reviewed the charges in this case and reimbursed Elite Healthcare in accordance with the Texas Workers' Compensation and Division Rules. Elite Healthcare has failed to show how Hartford's reimbursement was insufficient under the applicable regulatory provisions. Accordingly, no additional reimbursement is appropriate."

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 2 – November 5, 2013	97140, 97110, 97530, 99361	\$1,114.40	\$85.00

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 §134.600 sets out the guidelines for prospective and concurrent review of health care.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 119 – Benefit maximum for this time period or occurrence has been reached
 - 168 – Billed chare is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services
 - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
 - 247 – A payment or denial has already been recommended for this service

Issues

1. How are submitted services defined?
2. Did the requestor support services were authorized?
3. What is the rule pertaining to reimbursement of team conferences?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the medical bill finds the medical bill contains codes 97140, 97112, and 97110. Each of these codes state, "billed in 15-minute units." As the authorization is specific to units not sessions, the services in dispute will reviewed based on applicable authorized total units.
2. The requestor states in the pertinent part, "These sessions were all authorized therapy." 28 Texas Labor Code §134.600 (p) states in pertinent part, " 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 finds the following; Document from Segwick dated July 30, 2013

<u>Category</u>	<u>Reference#</u>	<u>Certified Units</u>	<u>Start Date</u>	<u>End Date</u>
Physical Therapy	1130589	3	7/29/2013	8/30/2013
Physical Therapy	1130589	3	7/29/2013	8/30/2013
Physical Therapy	1130589	3	7/29/2013	8/30/2013

The submitted medical bill finds;

<u>Date of service</u>	<u>number of units billed</u>	<u>number of units paid by Carrier</u>
August 2, 2013	8 units	4 (2) of 97112 and (2) of 97110
August 12, 2013	8 units	4 (2) of 97112 and (2) of 97110
August 14, 2013	8 units	4 (2) of 97112 and (2) of 97110

Document from Sedwick dated October 25, 2013

<u>Category</u>	<u>Reference#</u>	<u>Certified Units</u>	<u>Start Date</u>	<u>End Date</u>
Physical Therapy	1202250	3	10/25/2013	11/23/2013
Physical Therapy	1202250	3	10/25/2013	11/23/2013
Physical Therapy	1202250	3	10/25/2013	11/23/2013
Physical Therapy	1202250	3	10/25/2013	11/23/2013

The submitted medical bill finds;

<u>Date of service</u>	<u>number of units billed</u>	<u>number of units paid by Carrier</u>
October 29, 2013	8 units	4 units (2) 97112 (1) 97530 and (1)97110
November 12, 2013	8 units	4 units (2) 97112 (2) 97110

Based on the above the requestor submitted more units than were authorized. Review of the Carrier's payments finds the dates of service in dispute did receive payment for the number of certified units. The requestor's position is not supported.

3. 28 Texas Administrative Code §134.204 (e) states in pertinent part, "(4) Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows: (A) CPT Code 99361. (i) Reimbursement to the treating doctor shall be \$113. Modifier "W1" shall be added..." Review of the submitted documentation finds that Dr. Michael Holder is the treating physician and therefore the amount allowed should have been \$113.00.
4. The total recommended payment for the services in dispute is \$113.00. This amount less the amount previously paid by the insurance carrier of \$28.00 leaves an amount due to the requestor of \$85.00. 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 \$85.00.

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 \$85.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		March 2, 2015
Signature	Medical Fee Dispute Resolution Officer	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.