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
Commerce & Industry Insurance

MFDR Tracking Number
M4-14-3068-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 9, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Treating provider visited with the patient to see progress the patient was having while in the work hardening program at our office."

Amount in Dispute: $112.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the provider billed for services that are included in the work hardening program. A doctor is expected to check the progress of the work hardening program as part of the program. This in not billed separately from the work hardening."

Response Submitted by: AIG, P.O. Box 25794, Shawnee Mission, KS 66225

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 18, 2014	99213	$112.33	$108.33

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 medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - A1 –Claim/Service denied
   - 2 – Routine progress and routine final reports filed by the attending physician do not ordinarily command a fee.

Issues

1. Did the requestor support that disputed service is separately payable?
2. What is the rule applicable fee guidelines?

3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as, "Routine progress and routine final reports filed by the attending physician do not ordinarily command a fee." 28 Texas Administrative Code 134.204 (h) states in pertinent part, "(2) For Division purposes, General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning. (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WC." Each additional hour shall be billed using CPT Code 97546 with modifier "WC." CARF accredited Programs shall add "CA" as a second modifier. (B) Reimbursement shall be $36 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 eight minutes and less than 23 minutes." 28 Texas Administrative Code 134.203 (b) states in pertinent part, "(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 bill finds the disputed service was submitted as CPT code 99213. This code is described as, "Office or other outpatient visit for the evaluation and management of an established patient." Based on the above no exclusion of a health care provider billing a professional evaluation and management service was found. The carrier's denial is not supported. Therefore the services in dispute will be reviewed per applicable rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.203 (c) 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 yearly conversion factor)". The service in dispute will be calculated as follows;
    - Procedure code 99213, service date February 19, 2014, 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 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.97. The practice expense (PE) RVU of 1 multiplied by the PE GPCI of 0.916 is 0.916. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.816 is 0.05712. The sum of 1.94312 is multiplied by the Division conversion factor of $55.75 for a MAR of $108.33.
3. The total allowable reimbursement for the services in dispute is $108.33. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $108.33. 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 $108.33.

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 $108.33 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.