



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

MILLENNIUM CHIROPRACTIC

**Respondent Name**

PROTECTIVE INSURANCE CO

**MFDR Tracking Number**

M4-14-3351-01

**Carrier's Austin Representative**

Box Number 17

**MFDR Date Received**

JULY 07, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "(197) Payment adjusted for absence of precert/preauth. The outstanding services rendered on **8/26/13, 8/29/13, 9/5/13, and 9/12/13** in which the carrier has denied based on the denial code (197) as listed above, are actually pre-authorized services. **The carrier's URA, CorVel, APPROVED six Physical Therapy sessions per the letter faxed to us on 8/15/13, ref # 49903187-UMO-1 (see attached approval letter).** The six pre-authorized services were rendered on 8/15/13, 8/22/13, 8/26/13, 8/29/13, 9/5/13, and 9/12/13 which immediately followed the pre-authorization approval. Two of the six pre-authorized services were paid accordingly. However, the pre-authorized services rendered on **8/26/13, 8/29/13, 9/5/13, and 9/12/13** were not. Our bills were submitted to you properly, timely, with sufficient documentation, and must be paid accordingly.

Additionally, the outstanding services rendered on **10/24/13** denied by the same **denial code (197)** as listed above, are also pre-authorized services. **The carrier's URA, CorVel, APPROVED four additional Physical Therapy sessions per the letter faxed to us on 10/9/13, ref # 49903187-UMO-3 (see attached approval letter).** These outstanding pre-authorized services rendered on 10/24/13 were properly documented, billed accurately and timely, and must be paid accordingly."

**Amount in Dispute:** \$1,463.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** The respondent did not submit a response to this request for medical fee dispute resolution.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 26, 2013 August 29, 2013 September 5, 2013 September 12, 2013 October 24, 2013	CPT Code G0283-GP Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care	\$24.00/day	\$111.50
August 26, 2013 August 29, 2013 September 5, 2013 September 12, 2013 October 24, 2013	CPT Code 97112-59-GP Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	\$47.56/day	\$237.80

August 26, 2013 September 5, 2013 September 12, 2013 October 24, 2013	CPT Code 97140-59-GP Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	\$42.50/day	\$170.00
August 26, 2013 August 29, 2013 September 5, 2013 September 12, 2013 October 24, 2013	CPT Code 97110-GP (X4) Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	\$187.04/day	\$935.20
TOTAL		\$1,463.00	\$1,454.50

### ***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 §134.600, requires preauthorization for specific treatments and services.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 197-Payment denied reduced for absence of, or exceeded, pre-certification/authorization. Procedure not approved by pre-authorization.
  - W3-Additional payment made on appeal/reconsideration.
  - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
5. 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 July 16, 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.

#### **Issues**

1. Does a preauthorization issue exist?
2. Is the requestor entitled to reimbursement?

#### **Findings**

1. According to the submitted explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code "197."

Per 28 Texas Administrative Code §134.600(p)(5)(A) the non-emergency healthcare that requires 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."

On August 15, 2013, the requestor obtained preauthorization approval for six (6) sessions of physical therapy, CPT codes 98941, 97140, 97110, G0283 and 97112, to be rendered three (3) X a week for two (2) weeks, effective August 12, 2013 through November 15, 2013.

On October 9, 2013 four (4) additional sessions were preauthorized, effective October 4, 2013 through December 20, 2013.

Review of the submitted documentation finds that the requestor provided fifteen (15) physical therapy sessions from August 15, 2013 through October 31, 2013: August 15, 2013, August 22, 2013, August 26, 2013, August 29, 2013, September 5, 2013, September 12, 2013, September 16, 2013, September 19, 2013, September 30, 2013, October 3, 2013, October 10, 2013, October 21, 2013, October 24, 2013, October 30, 2013 and October 31, 2013.

The submitted EOBs indicate that payment was issued for physical therapy services rendered on August 15, 2013 and August 22, 2013. Based upon the preauthorization approval, eight physical therapy sessions remain preauthorized; therefore, payment is recommended for the disputed services.

- 2. Per 28 Texas Administrative Code §134.203(c)(1)(2), "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 \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2013 DWC conversion factor for this service is 55.3.

The Medicare Conversion Factor is 34.023

Review of Box 32 on the CMS-1500 the services were rendered in zip code 75061 in Irving, Texas. Per Medicare the provider is reimbursed using the locality of Dallas, Texas.

Using the above formula the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable Reimbursement	Total Paid	Total Due
G0283	\$13.72	\$22.30 X 5 dates = \$111.50	\$0.00	\$111.50
97140	\$30.27	\$49.20, requestor is seeking lesser amount of \$42.50 X 4 dates = \$170.00	\$0.00	\$170.00
97110 (X4)	\$32.34	\$52.56 X 4 = \$210.24, requestor is seeking lesser amount of \$187.04 X 5 dates = \$935.20	\$0.00	\$935.20
97112	\$33.72	\$54.81, requestor is seeking lesser amount of \$47.56 X 5 dates = \$237.80	\$0.00	\$237.80

**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 \$1,454.50.

**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 \$1,454.50 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

08/28/2014  
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.**