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 Garland

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-14-3669-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 15, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...Office Visits are deemed medically necessary to evaluate and treat the patient and provide a plan of care in which includes the patient return to work status."

Amount in Dispute: $518.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company has determined additional monies are owed in the amount of $308.92."

Response Submitted by: Gallagher Bassett, 6404 International Parkway, Suite 2300, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 23, 2014	99213, 97140, 97112, 97110	$518.05	$0.00

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.210 sets out requirements of medical documentation.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.
4. 28 Texas Administrative Code §129.5 sets out guidelines for work status reports.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 112 – Service not furnished directly to the patient and/or not documented
   - W3 – Request for reconsideration
   - 16 - Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

Issues

1. Did the requestor support documentation requirements are met?

2. What is the applicable rule pertaining to reimbursement?
3. Are requirements of work status report met?
4. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as 112 – "Service not furnished directly to the patient and/or not documented" and 16 – "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication." Per 28 Texas Administrative Code §133.210 (b) When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents.(c) In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation: (1) the two highest Evaluation and Management office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes;" Review of the submitted documentation finds;
    - Note dated April 23, 2014 does not provide legible details to support billing 99213.
    - The "signature" is not legible to support that the physician submitting the visit signed this note.
    - Note section titled "Manual therapy" is blank. Nothing to support service provided was found

   Therefore, the Division finds the requirements of Rule 133.210(b) have not been met for CPT code 99213 and 97140. The remaining items in dispute will be reviewed per applicable rules and fee guidelines.

2. Per 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 annual conversion factor).
    - Procedure code 97112, service date April 23, 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 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 0.4563. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 1.013 is 0.48624. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.803 is 0.00803. The sum of 0.95057 is multiplied by the Division conversion factor of $55.75 for a MAR of $52.99. 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 reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $52.99. The PE reduced rate is $39.44. The total is $92.43.
    - Procedure code 97110, service date April 23, 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 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 0.4563. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.013 is 0.44572. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.803 is 0.00803. The sum of 0.91005 is multiplied by the Division conversion factor of $55.75 for a MAR of $50.74. 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 reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $38.31 at 4 units is $153.24.

3. 28 Texas Administrative Code §129.50 (i) states, "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15."

4. The total allowable reimbursement for the services in dispute is $260.67. This amount less the amount previously paid by the insurance carrier of $308.92 leaves an amount due to the requestor of $0.00. No

additional reimbursement 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	Peggy Miller Medical Fee Dispute Resolution Officer	January 15, 2015 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.