



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Fondren Orthopedic

Respondent Name

New Hampshire Insurance Co

MFDR Tracking Number

M4-16-0637-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have received the denial on the corrected bill we submitted for payment but we disagree with this denial because added the following G codes to the claim to support the PT charges. Please review the claim and send us the payment we are due for this claim."

Amount in Dispute: \$193.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: 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 November 9, 2015. The insurance carrier did not submit a response for consideration in this review. Per 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." Accordingly, this decision is based on the available information.

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|-------------------|---|-------------------|------------|
| February 17, 2015 | 97002 -59, GP 97110 -GP G0283 -GP | \$193.26 | \$162.15 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
 - BL – This bill is a reconsideration of a previously reviewed bill, allowance amounts do not reflect previous payments
 - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
 - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed service 97002 with claim adjustment reason code 16 – "Claim/Service lacks information or has submission/billing effort(s) which is needed for adjudication and 4 – "The procedure code is inconsistent with the modifier used or a required modifier is missing. 28 Texas Administrative Code §134.203(b) states,

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;

The applicable Medicare payment policy is found at

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf

Medicare Claims Processing Manual, Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services

G. Required Reporting of Functional G-codes and Severity Modifiers

The functional G-codes and severity modifiers listed above are used in the required reporting on therapy claims at certain specified points during therapy episodes of care. Claims containing these functional G-codes must also contain another billable and separately payable (non-bundled) service. Only one functional limitation shall be reported at a given time for each related therapy plan of care (POC).

Functional reporting using the G-codes and corresponding severity modifiers is required reporting on specified therapy claims. Specifically, they are required on claims:

- *At the outset of a therapy episode of care (i.e., on the claim for the date of service (DOS) of the initial therapy service);*
- *At least once every 10 treatment days, which corresponds with the progress reporting period;*
- *When an evaluative procedure, including a re-evaluative one, (HCPCS/CPT codes 92521, 92522, 92523, 92524, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, **97002**, 97003, 97004) is furnished and billed;*

Review of the explanation of benefits with DCN # "2015162F6529007" finds;

- G8978 - Mobility: walking & moving around functional limitation, current status, at therapy episode outset and at reporting intervals
- G8979 - Mobility: walking & moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
- GP modifier - Services delivered under an outpatient physical therapy plan of care

Pursuant to Rule 134.203(b) the carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code 134.203 (c) states,

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).

The maximum allowable reimbursement is calculated as follows:

- Procedure code 97002 -59, GP, service date February 17, 2015. 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 0.6 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.6114. The practice expense (PE) RVU of 0.56 multiplied by the PE GPCI of 1.006 is 0.56336. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 1.19386 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$67.09. 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 \$67.09.
 - Procedure code 97110 -GP, service date February 17, 2015. 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 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.006 is 0.44264. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.92029 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$51.72. 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 \$39.28 at 2 units is \$78.56.
 - Procedure code G0283 -GP, service date February 17, 2015. 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 0.18 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.18342. The practice expense (PE) RVU of 0.2 multiplied by the PE GPCI of 1.006 is 0.2012. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.955 is 0.00955. The sum of 0.39417 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$22.15. 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 \$16.50.
3. The total allowable reimbursement for the services in dispute is \$162.15. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$162.15. 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 \$162.15.

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 \$162.15 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 , 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, 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 MFDR 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.