



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

Texas Health DBA Injury 1 of Dallas

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-16-0517-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

October 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was originally mailed on 03/25/15, faxed on 05/27/15 ..., and refaxed on 07/24/15 ... therefore the claim was timely filed."

Amount in Dispute: \$234.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual reviewed its claim file and found no record of receiving either the clinical notes or the bill for the disputed dates prior to receiving the bill on 7/24/15."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 25, 2015	Physical Therapy (97110, 97530)	\$234.00	\$213.56

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.20 sets out the procedures for submitting medical bills.
- 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - CAC-29 – The time limit for filing has expired.
 - 731 – Per 133.20(b) provider shall not submit a medical bill later than the 95th day after the date the service.

- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724 – No additional payment after a reconsideration of services.
- CAC-18 – Exact duplicate claim/service.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code CAC-29 – "THE TIME LIMIT FOR FILING HAS EXPIRED," and 731 – "PER 133.20(B) PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE." 28 Texas Administrative Code §133.20 (b) requires that "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided..." Review of the submitted information supports that the requestor submitted the medical bill for the disputed services on May 27, 2015, which is within 95 days from the date of service. The insurance 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 \$52.83...
- (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 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. The Division conversion factor for 2015 is \$56.20.

For CPT code 97530 on March 25, 2015, the relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.447920. The practice expense (PE) RVU of 0.53 multiplied by the PE GPCI of 1.009 is 0.534770. 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 reduced PE for subsequent units is 0.267385. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.772 is 0.007720. The sum of the calculations for the first unit, 0.990410, is multiplied by the Division conversion factor of \$56.20 for a total of \$55.66. The sum of the calculations for subsequent units, 0.723025, is multiplied by the Division conversion factor of \$56.20 for a total of \$40.63. The total MAR for 2 units is \$96.29.

For CPT code 97110 on March 25, 2015, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.458100. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.009 is 0.443960. 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 reduced PE is 0.221980. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.772 is 0.015440. The sum of 0.695520 is multiplied by the Division conversion factor of \$56.20 for a total of \$39.09. The total MAR for 3 units is \$117.27.

3. The total MAR for the disputed services is \$213.56. The insurance carrier paid \$0.00. A reimbursement of \$213.56 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 \$213.56.

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 \$213.56 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	<u>Laurie Garnes</u>	<u>November 13, 2015</u>
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, 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.