



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 BONE AND JOINT CENTER

Respondent Name

CITY OF FORT WORTH

MFDR Tracking Number

M4-16-1011-01

Carrier's Austin Representative

Box Number 04

MFDR Date Received

DECEMBER 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting payment in full at this time due to the fact this was a clean claim."

Amount in Dispute: \$377.00

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
February 11, 2015	CPT Code 97001-GP	\$377.00	\$118.17

Dates of Service	Billing Codes Noted (not in dispute)	Amount In Dispute
February 11, 2015	G8978CL, G8981CL, G8984CL, G8987CL and G8990-CL	\$0.00

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.

2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P14-The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.
 - R4-Non-covered procedure per state regulations.
 - R38-Included in another billed procedure.
 - W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor entitled to reimbursement for the disputed physical therapy service rendered on February 11, 2015?

Findings

28 Texas Administrative Code §134.203(a)(5) states “Medicare payment policies” when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.”

CPT code 97001 is defined as “Physical therapy evaluation.”

The requestor appended modifier “GP- Services delivered under an outpatient physical therapy plan of care.”

The respondent denied reimbursement for code 97001-GP based upon “The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.” The Division reviewed the submitted documentation and finds that the respondent’s denial is not supported because code 97001 was the only code billed on that day that is reimbursable; therefore, reimbursement is recommended.

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: $(\text{DWC Conversion Factor}/\text{Medicare Conversion Factor}) \times \text{Participating Amount} = \text{Maximum Allowable Reimbursement (MAR)}$.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 76180, which is located in North Richland Hills, Texas; therefore, the Medicare participating amount is based on locality “Fort Worth, Texas”.

The 2015 DWC conversion factor for this service is 56.2.

The 2015 Medicare Conversion Factor is 35.7547.

The Medicare Participating Amount for this code is \$75.18.

Using the above formula, the Division finds the MAR is \$118.17. The respondent paid \$0.00. As a result, reimbursement 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 \$118.17.

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 \$118.17 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	Date
		03/30/2016

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.