



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

Ultimate Pain Solutions

Respondent Name

Alief ISD

MFDR Tracking Number

M4-16-1122-01

Carrier's Austin Representative

Box Number 21

MFDR Date Received

December 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute: \$260.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On or about September 10, 2015, Requestor submitted billing for service date July 31, 2015. On October 15, 2015, Explanation of Review was issued on October 15, 2015, notifying that Claim/Service Lacks information which is needed for adjudication..."

On November 9, 2015, more that [sic] the 15th day after receipt of a request for additional medical documentation, Requestor submitted records stating, 'I am in receipt of an EOB for dates of service 04/31/15 that were denied because of code 16. I have attached a copy of the physical therapy note and would like to have my services reprocessed.'

As the submitted records were beyond the 15th day after receipt of a request for additional medical documentation, Respondent issues EOB notifying of \$0.00 in allowance, notifying that the time limit for the filing has expired."

Response Submitted by: Thornton, Biechlin, Reynolds, & Guerra

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 31, 2015, Physical Therapy (97110 & 97140), \$260.00, \$163.94

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 §133.2 defines terms used regarding medical billing and processing.
3. 28 Texas Administrative Code §133.210 sets out the procedures regarding medical documentation.
4. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
5. 28 Texas Administrative Code §133.250 sets out the procedures for reconsideration of a medical bill.
6. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 16 – Claim/service lacks information which is needed for adjudication.
  - 29 – The time limit for filing has expired.

## Issues

1. Did the insurance carrier request additional documentation in accordance with 28 Texas Administrative Code §133.210?
2. Is the insurance carrier's denial for timely filing supported?
3. What is the maximum allowable reimbursement (MAR) for the disputed services?
4. Is the requestor entitled to reimbursement for the disputed services?

## Findings

1. 28 Texas Administrative Code §133.240(d) provides that "The insurance carrier may request additional documentation, in accordance with §133.210 of this title ..., not later than the 45th day after receipt of the medical bill to clarify the health care provider's charges." 28 Texas Administrative Code §133.210(d) requires that

Any request by the insurance carrier for additional documentation to process a medical bill shall:

- (1) be in writing;
- (2) be specific to the bill or the bill's related episode of care;
- (3) **describe with specificity the clinical and other information to be included in the response** [emphasis added];
- (4) be relevant and necessary for the resolution of the bill;
- (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
- (6) **indicate the specific reason for which the insurance carrier is requesting the information** [emphasis added]; and
- (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.

Review of the submitted documentation does not support that the insurance carrier made a request for additional documentation with the specificity required by 28 Texas Administrative Code §133.210.

2. On their Explanation of Review dated December 9, 2015, the insurance carrier denied the disputed services with claim adjustment reason code 29 – "THE TIME LIMIT FOR FILING HAS EXPIRED." In their position statement, the insurance carrier argued that this denial was because "submitted records were beyond the 15<sup>th</sup> day after receipt of a request for additional medical documentation." 28 Texas Administrative Code §133.240(a) states,

An insurance carrier shall take **final action** [emphasis added] after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter ..., not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

28 Texas Administrative Code §133.250 states, in relevant part,

- (a) If the health care provider is dissatisfied with the insurance carrier's **final action** [emphasis added] on a medical bill, the health care provider may request that the insurance carrier reconsider its

action. If the health care provider is requesting reconsideration of a bill denied based on an adverse determination, the request for reconsideration constitutes an appeal for the purposes of §19.2011 of this title ... and may be submitted orally or in writing.

- (b) The health care provider shall submit the request for reconsideration no later than 10 months from the date of service.

28 Texas Administrative Code §133.2(6) defines final action on a medical bill as:

- (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or
- (B) denying a charge on the medical bill.

Review of the submitted documentation supports that the insurance took final action on the medical bill for the disputed services with an Explanation of Review dated October 16, 2015, denying the charges in question. In accordance with 28 Texas Administrative Code §133.250(b) the health care provider was obligated to submit a request for reconsideration within 10 months from the date of service if they disagreed with the final action of the insurance carrier. Review of the submitted documentation finds that the health care provider submitted a request for reconsideration on November 9, 2015, which is less than 10 months from the date of service. The insurance carrier's denial for this reason is not supported.

- 3. 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 97110 on July 31, 2015, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.458550. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.006 is 0.42640. 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 0.221320. The malpractice RVU of 0.02 multiplied by the malpractice (MP) GPCI of 0.955 is 0.019100. The sum of the calculations for the first unit, 0.019100, is multiplied by the Division conversion factor of \$56.20 for a total of \$51.72. The sum of the calculations for subsequent units, 0.698970, is multiplied by the Division conversion factor of \$56.20 for a total of \$39.28. The total MAR for 2 units is \$91.00.

For CPT code 97140 on July 31, 2015, the RVU for work of 0.43 multiplied by the GPCI for work of 1.019 is 0.438170. The PE RVU of 0.40 multiplied by the PE GPCI of 1.006 is 0.402400. 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 0.201200. The MP RVU of 0.01 multiplied by the malpractice GPCI of 0.955 is 0.009550. The sum of 0.648920 is multiplied by the Division conversion factor of \$56.20 for a total of \$36.47. The total MAR for 2 units is \$72.94.

- 4. The total MAR for the disputed services is \$163.94. The insurance carrier paid \$0.00. A reimbursement of \$163.94 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 \$163.94.

***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 \$163.94 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

|           |  |               |
|-----------|--|---------------|
|           | Laurie Garnes                          | April 6, 2016 |
| 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.**