



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

BRIAN LUCOSKI, PT
OCCMED ASSOCIATES, LP

Respondent Name

CITY OF LUBBOCK

MFDR Tracking Number

M4-16-1272-01

Carrier's Austin Representative

Box Number 22

MFDR Date Received

JANUARY 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We believe this bill was reviewed incorrectly on two separate occasions as each bill is specifies different specialties and two separate providers providing the services and so therefore each bill is entitled to its own separate review and guidelines."

Amount in Dispute: \$99.79

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

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include May 22, 2015 with CPT codes 97001-GP-59, G8978-GP, G8979-GP and a TOTAL row.

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, 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:
 - 148-This procedure on this date was previously reviewed.
 - 18-Exact duplicate claim/service.
 - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
 - W3-Additional payment made on appeal/reconsideration.
 - 193-Original payment decision is being maintained. This claim was processed properly the first time.

Issues

Is the requestor entitled to reimbursement for the disputed physical therapy service rendered on May 22, 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,” and “59- Distinct Procedural Service” to code 97001.

The requestor wrote in the letter requesting reconsideration of payment for code 97001-GP-59 that “ This claim is not a duplicate, the patient saw an MD and PT different subspecialties on the same DOS.” The Division reviewed the submitted documentation and finds that the respondent’s denial is not supported; 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: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

Review of Box 32 on the CMS-1500 the services were rendered in zip code 79412, which is located in Lubbock, Texas; therefore, the Medicare participating amount is based on locality “Rest of Texas”.

The 2015 DWC conversion factor for this service is 56.2.

The 2015 Medicare Conversion Factor is 35.9335.

The Medicare Participating Amount for this code is \$73.06.

Using the above formula, the Division finds the MAR is \$114.27 or less. The requestor is seeking reimbursement of \$99.79. 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 \$99.79.

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 \$99.79 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	03/31/2016 Date
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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.