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
Hand and Wrist Center of Houston

Respondent Name
Employers Preferred Insurance Company

MFDR Tracking Number
M4-16-2907-01

Carrier's Austin Representative
Box Number 4

MFDR Date Received
May 23, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The healthcare provider's position on this claim is that this date of service has been partially denied. We find that one of the charges on this claim has not been paid at 100% of the statutory fee as required by law per Texas Administrative Code Title 28 Part 2 Chapter 134 Subchapter C Rule 134.202"

Amount in Dispute: $190.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was denied requesting the rendering physician's state license number. Per Texas administrative code 133.10, this is a requirement for billing."

Response Submitted by: Bunch Care Solutions

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 12, 2015	Occupational Therapy	$190.48	$127.47

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 fee guidelines for professional services.
3. 28 Texas Administrative Code §134.600 sets out the procedures for preauthorization.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Per TX Rule 134.600, Pre-auth is required. If services have been pre-authorized re submit the bill with authorization info for reconsideration.

- Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did the insurance carrier appropriately raise an issue regarding the requestor's license number?
2. Is the insurance carrier's reason for denial of payment 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. In their position statement, the insurance carrier argued that "The bill was denied requesting the rendering physician's state license number." 28 Texas Administrative Code §133.307(d)(2)(F) states, in relevant part,

   > The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review…

   Review of the submitted documentation does not support that the issue in question was raised prior to the date the request for MFDR was filed. Therefore, this issue will not be considered.

2. The requestor is seeking reimbursement of occupational therapy procedure codes 97110 and 97140 for date of service November 12, 2015. The insurance carrier denied disputed services stating, "Per TX Rule 134.600, Pre-auth is required. If services have been pre-authorized re submit the bill with authorization info for reconsideration." 28 Texas Administrative Code §134.600(c) provides that:

   > The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:
   > (1) listed in subsection (p) or (q) of this section only when the following situations occur:
   > (A) …
   > (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care

   Review of the submitted information finds a utilization review notice dated November 10, 2015 which approved preauthorization for occupational therapy for three times a week for four weeks, including procedure codes 97140 and 97110. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

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 November 12, 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 0.442640. 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, 0.920290, 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 November 12, 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 1 unit is $36.47.

4. The total MAR for the disputed services is $127.47. The insurance carrier paid $0.00. A reimbursement of $127.47 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 $127.47.

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 in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $127.47 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	June 22, 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.