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
Patient Care Injury Clinic

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-18-4216-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 3, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The MFDR is submitted out of the time frame, however; the division's commissioner issued bulletin #B-0020-17. The proclamation states that system participants who reside within the counties listed have the right for the Texas worker's compensation deadlines to be tolled through the duration of the proclamation."

Amount in Dispute: $383.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This request is untimely."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 27, 2016	97110, 97140, 97112, G0283	$383.48	$303.87

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 §134.600 sets out the requirements of prior authorization.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 165 – Payment denied/reduced for absence of, or exceeded referral

- 5094 – DWC requires request for reconsideration or corrected claims to be submitted within 10 months of the date of service
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Is this dispute subject to Texas Governor's Disaster Proclamation?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What rule is applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states, "The disputed service date is October 27, 2016. Requestor's DWC-60 is stamped as received by the Division on July 3, 2018. A provider must request medical dispute resolution on a fee issue or a retrospective medical necessity review within one year of the date of service. …None of the exceptions to this rule in 28 TAC 133.307 (c)(1)(B) are applicable to this case."

   The Division's Commissioner issued Bulletin # B-0020-17 which states in pertinent part,

   "For system participants who reside in the counties listed in the Governor's disaster proclamation, the Texas workers' compensation deadlines for the following procedures are tolled through the duration of the Governor's disaster proclamation:

   - Workers' compensation claim notification and filing deadlines.
   - Medical billing deadlines.
   - Medical and income benefit payment deadlines
   - Electronic date reporting deadlines, and
   - Medical and income benefit dispute deadlines

   Review of the submitted medical bill found the zip code of 77076 in Harris County. This county is found within the "Proclamation by the Governor of the State of Texas" disaster declaration. The one year deadline was paused at the time of the Governors Proclamation (August 23, 2017) and began again on January 10, 2108 with Commissioner's Bulletin B-0042-17. Review of the submitted documentation finds that only 301 days had elapsed. Therefore, this requestor has not waived their right to MFDR. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. The insurance carrier denied disputed services with claim adjustment reason code 165 – "Payment denied/reduced for absence of, or exceeded referral."

   28 Texas Administrative Code §134.600 (p)(5) states in pertinent part,

   Non-emergency health care requiring preauthorization includes:

   (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

   (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

   Review of the submitted documentation founds letter from Sedgwick dated October 21, 2016 that indicates;

   Physical Therapy Reference # 2215310 Start Date 10/20/2016 End Date 2/20/2017

   As the date of service in dispute is within this range, the carrier's denial is not supported. The service in dispute will be reviewed per applicable Division fee guidelines.

2. 28 Texas Administrative Code 134.203 (c) states in pertinent part,

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

The MAR is calculated by the DWC Conversion Factor/Medicare Conversion Factor multiplied by the Medicare Allowable.

On April 1st of 2013, Medicare implemented the Medicare Multiple Procedure Payment Reduction (MPPR). The MPPR policy may be found in the CMS Claims Processing Manual 100-04, Chapter 5, section 10.7 found at www.cms.gov. The MPPR policy applies and will be used in the calculation of the maximum allowable reimbursement shown below.

- Procedure code 97110, four units has a PE of 0.44 not the highest for this date and will be paid at the reduced allowable of $25.03. 56.82/35.8043 x $25.03 x 4 = $158.89
- Procedure code 97140, two units has a PE of 0.4 not the highest for this date and will be paid at the reduced allowable of $23.23. 56.82/35.8043 x $23.23 x 2 = $73.73
- Procedure code 97112, has a PE of 0.48 the highest for this date and will be paid at the full allowable of $34.39. 56.82/35.8043 x $34.39 = $54.57
- Procedure code G0283, has a PE of 0.2 not the highest for this date and will be paid at the reduced allowable of $10.51. 56.82/35.8043 x $10.51 = $16.68

The total allowed amount is $303.87. This amount 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 $303.87.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $303.87, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		July 27, 2018
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 Rule §133.307, effective May 31, 2012, *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. **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.