MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DALLAS TESTING, INC

Respondent Name
GREAT WEST CASUALTY CO

MFDR Tracking Number
M4-19-0719-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
OCTOBER 10, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient had a hearing where it was determined that he had reached MMI on December 7, 2017. However, **under the workers compensation act of the Texas labor code and injured employee is entitle to lifetime medical treatment for a compensable injury**."

Amount in Dispute: $130.77

RESPONDENT

The respondent's positions are not to be considered. See Rule 28 Texas Administrative Code §133.307(d)(2)(F). No denial reasons were presented to the provider before the filing of this medical fee dispute. Great West Casualty Co failed to issue an explanation of benefits for the service in dispute within the timeframe specified in Texas Labor Code 408.027(b) and corresponding 28 Texas Administrative Code §133.240.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 2, 2017	CPT Code 97163-GP	$130.77	$130.77
	CPT Code G8978-GP-CI	0.00	$0.00
	CPT Code G8980-GP-CH	$0.00	$0.00
TOTAL		$130.77	$130.77

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, effective May 31, 2012, sets out the procedures for resolving

medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the health care providers billing procedures.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. 28 Texas Administrative Code §133.250 sets out the medical bill processing and audit by insurance carriers procedures.
5. Neither party to this dispute submitted any explanation of benefits for the services rendered on November 2, 2017.

Issues

Is the requestor entitled to reimbursement?

Findings

1. The fee guidelines for disputed services is found at 28 Texas Administrative Code §134.203.
2. On the disputed dates of service, the requestor billed CPT codes 97163-GP, G8978-GP-CJ and G8980-GP-CH. Only CPT code 97163-GP is in dispute.
3. 28 Texas Administrative Code §133.240(a) states, "An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill."

   Although the requestor provided evidence to support that it sent a complete medical bill to the respondent, no evidence was presented by the respondent to support that it issued an explanation of benefits to the within 45 days; nor did the respondent present any evidence to support that it responded to the request for reconsideration.

   No defenses were presented to the provider before the filing of this medical fee dispute. Pursuant to 28 TAC 133.307(d)(2)(F), the defenses raised by the respondent in its position statement are new defenses and will not be considered in this review. Consequently, the services in dispute are eligible for payment.
4. Per 28 Texas Administrative Code §134.203(a)(5), "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 97163 is described as "Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family."

   GP modifier is described as "Services delivered under an outpatient physical therapy plan of care."

   The requestor submitted a report to support billed service; therefore, reimbursement is recommended.

7. 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 761111, which is located in Fort Worth, Texas; therefore, the Medicare participating amount is based on locality "Fort Worth, Texas".

The 2017 DWC conversion factor for this service is 57.5.

The Medicare conversion factor is 35.8887.

The Medicare participating amount for code 97163 in Fort Worth, TX is $81.62.

Using the above formula, the Division finds the MAR is $130.77. The respondent paid $0.00. The requestor is due the difference of $130.77.

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 $130.77.

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 $130.77 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
		03/28/2019

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.