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
NORTH TEXAS PAIN RECOVERY CENTER

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-3638-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 29, 2019

Response Submitted by:
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"NTPRC did provide services to the above-mentioned claimant. A CCH was held to determine the network status of this claim pursuant to Insurance Code § 1305.005 and§ 1305.451. Subsequently, a decision was rendered that the claim was not a network claim, the claimant was not required to follow network rules, and that any fee dispute would be pursuant to Labor Code § 413. Because the claim was originally treated as a network claim, the enclosed FCE was billed to One Call Physical Therapy, an agent or entity of Texas Mutual Insurance Company. (Non-Network FCE bills would be processed by Texas Mutual rather than One Call."

RESPONDENT'S POSITION SUMMARY

"The following is the carrier's statement with respect to this dispute. This dispute involves the provider requesting the carrier's payment for date of service 7/25/2018 to 7/25/2018. The requester billed $207.92; however, Texas Mutual has no record of receiving a bill from the provider. Because Texas Mutual has not reduced or denied payment of a bill from the provider no dispute exists. Although there is a bill in the provider's DWC60 packet, which Texas Mutual has no record of receiving, if Texas Mutual adjudicated that bill today it would be denied as untimely per Rule 133.20. No payment is due."

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
July 25, 2018	97750-FC	$207.92	$207.92

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.210 sets out the medical documentation procedure.
3. 28 TAC §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Neither party submitted EOBS for consideration in this dispute.

Issue(s)

1. Does MFDR have jurisdiction to adjudicate the medical fee dispute?
2. Did the requestor meet the requirement of 133.307 (c) (2) (K)?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for an FCE rendered on July 25, 2018.

   The requestor states, "Subsequently, a decision was rendered that the claim was not a network claim, the claimant was not required to follow network rules, and that any fee dispute would be pursuant to Labor Code § 413."

   Review of the Decision & Order dated March 7, 2019 states in pertinent part, "The Employer did not provide the Claimant with the information required by Texas Insurance Code Sec 1305.005 and Sec. 1305.451. The Division does have jurisdiction to determine the medical fee dispute by North Texas Pain Recovery Center…"

   The DWC finds that medical fee dispute resolution has jurisdiction to adjudicate the medical fees surrounding this dispute.

2. Review of the DWC060 and the insurance carrier's response does not contain copies of EOBs with the request.

   28 TAC §133.307(c)(2)(K) states that "(K) each explanation of benefits or e-remittance (collectively "EOB") related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB."

   The DWC finds that the requestor submitted sufficient documentation to support that the bills in question were submitted to the insurance carriers for review. In addition, the requestor submitted sufficient documentation to support that an attempt was made to obtain the audit EOBs prior to the filing of the MDR. As a result, the DWC finds that the disputed service is eligible for review.

   Review of the Functional Capacity Evaluation report supports the billing of a 2-hour evaluation, rendered on July 25, 2018. As a result, the requestor is entitled to reimbursement for CPT Code 97750-FC.

3. 28 TAC §134.203(c)(1) 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."

   28 TAC §134.203(c)(2) states "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 Medicare Payment = Maximum Allowable Reimbursement (MAR).

On the disputed dates of service, the requestor billed CPT code 97550-FC (X8). The multiple procedure rule discounting applies to the disputed service.

Medicare Claims Processing Manual Chapter 5, 10.3.7-effective June 6, 2016, titled *Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services*, states:

> Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures with dates of service prior to April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment is made for the PE for services submitted on professional claims (any claim submitted using the ASC X12 837 professional claim format or the CMS-1500 paper claim form) and 75 percent payment is made for the PE for services submitted on institutional claims (ASC X12 837 institutional claim format or Form CMS-1450).
>
> For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 50 percent payment is made for the PE for services submitted on either professional or institutional claims.
>
> To determine which services will receive the MPPR, contractors shall rank services according to the applicable PE relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services. When the highest PE RVU applies to more than one of the identified services, contractors shall additionally sort and rank these services according to highest total fee schedule amount, and price the service with the highest total fee schedule amount at 100% and apply the appropriate MPPR to the remaining services.

The *MPPR Rate File* that contains the payments for 2018 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

- MPPR rates are published by carrier and locality.
- Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 76016 which is located in Arlington, Texas; therefore, the Medicare locality is "Fort Worth, Texas."
- The Medicare participating amount for CPT code 97750 at this locality is $38.15.
- The DWC conversion factor for 2018 is 58.31.
- The Medicare conversion factor for 2018 is 35.9996.

Using the above formula, the MAR is $61.79 for the first unit, and $44.54 at 7 units is $311.78 for a total reimbursement of $373.57. Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's charge. The lesser amount is $207.92.

4. Review of the submitted documentation finds that the requestor is entitled to $207.92. Therefore, this amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $207.92.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $207.92 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		May 21, 2021
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 TAC §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed, or personally delivered to the DWC 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 DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.