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

ELITE HEALTHCARE NORTH DALLAS

Respondent Name

LEWISVILLE ISD

MFDR Tracking Number

M4-20-2532-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 19, 2020

Response Submitted by:

Flahive, Ogden & Latson

REQUESTOR'S POSITION SUMMARY

"This claim was originally denied on the basis of 'the rendering provider is not eligible to perform the service billed'. This is INCORRECT. Per TDI rule 42.20a "licensed doctors of medicine, osteopathy, chiropractic, and podiatry may act as treating doctors for injured workers". Dr. Michael Adair is Susan's treating doctor; please see the attached notice from the Division saying as such and is there for eligible to treat the patient as necessary per TDI rules and ODG guidelines."

RESPONDENT'S POSITION SUMMARY

"On October 21, 2019, the claimant prepared a DWC-53, requesting to change treating doctors. However, DWC never acted on that DWC-53. Pursuant to Division rule 126.9 (c) the first doctor who provides health care to an injured employee shall be known as the injured employee's initial choice of treating doctor. There are some exceptions if the doctor was salaried by the employer or recommended by the carrier or employer. In this case, Dr. Um was not the doctor salaried by the employer nor was he a doctor recommended by the carrier or the employer. Accordingly, he was the claimant's initial choice of treating doctor. Although, it is the carrier's position that Dr. Um was not salaried by the employer nor recommended by the carrier or employer, but even if he had been, he had treated the claimant for more than 60 days at the time that the claimant prepared the DWC-53. Thus, the 60-day rule would apply in that situation, meaning that the claimant would be required to file a DWC-53 and have it approved by the Division. The carrier's position is that she was already required to do so because Dr. Um was not salaried by the employer nor recommended by the carrier or employer.

DWC has never acted on the claimant's DWC-53. In other words, there has never been a determination that the claimant was entitled to change treating doctors to Dr. Michael Adair, who's bill is the subject of the medical fee dispute...

The claimant's initial treating doctor was Dr. Dennis Um. There has never been any order issued by the Division that indicated that Dr. Adair was approved as the claimant's treating doctor. Accordingly, any health care provided by Dr. Adair had to be approved or recommended by Dr. Dennis Um. However, there is no relationship between Dr. Um and Dr. Adair. More specifically, Dr. Um never referred the claimant to Dr. Adair for any type of evaluation or treatment.

Accordingly, Dr. Adair is not entitled to any reimbursement. In fact, the Medical Review Division should dismiss the request for Medical Fee Dispute Resolution until there has been an approval of the DWC-53 dated October 21, 2019."

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
December 10, 2019	97110-GP x 4 units	$207.48	$171.48

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 §133.305 sets out the procedure for Medical Fee Dispute Resolution.
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:
   - 185 – The rendering provider is not eligible to perform the service billed
   - W3 – Reconsideration
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 1241 – No additional reimbursement allowed after review of appeal/reconsideration request for second review

Issue(s)

1. Does the insurance carrier's position summary and documentation support their reason for denial?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 97710-GP rendered on December 10, 2019. The insurance carrier denied/reduced the disputed service(s) with denial reduction code 185. The DWC finds the following:

   - Disputed services rendered by Dr. Adair
   - On 10/2019 the DWC53 approved Dr. Adair as the TD
   - The DOS in dispute is 12/10/19
   - On 12/11/19 DWC held a BRC with resolution: "IE to find a TD to treat injuries and a new DWC53 will be submitted."
   - On 1/6/20 IE found a TD with Wolmed and filed a new DWC53
   - On 1/9/20 WolMed doctor approved as TD by the DWC

   The DWC finds that the disputed service was rendered on December 10, 2019, the DWC approved Dr. Adair as the treating doctor on October 2019. Therefore, the DWC finds that the disputed services were rendered by the DWC approved TD. The DWC finds that the injured employees request to change treating doctor from Dr. Adair to a WolMed doctor was not approved by the DWC until January 9, 2020. As a result, the requestor is entitled to reimbursement for the disputed service.

2. 28 TAC §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

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

CPT Code 97110 is identified as an "always therapy code" which is subject to Medicare's MPPR edits.

3. 28 TAC §134.203 states in pertinent part, "(c) 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..."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

   The DWC conversion factor for 2019 is $59.19.

   The Medicare conversion factor for 2019 is 36.0391.

   Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 75006 located in Dallas, Texas.

   The Medicare participating amount for CPT code 97110 in Dallas, TX is $31.58.

   Using the above formula, the MAR is $51.87 for the first unit, and $39.87 for each additional unit (x 3 units = $119.61). The total MAR is $171.48. The respondent paid $0.00. The requestor is due the difference between MAR and amount paid of $171.48.

4. Review of the submitted documentation finds that the requestor is entitled to a total recommended amount of $171.48.

<u>Conclusion</u>

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 $171.48.

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 $171.48 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 9, 2020 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.