Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DIPTI PATEL DC

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-09-5247-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
January 14, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility obtained a pre-authorization for these services. In addition the carrier did NOT respond to the RFR."

Amount in Dispute: $315.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "... based on information provided in Dr. Patel's medical dispute resolution request and in an effort to resolve this matter, without incurring further time and expense associated with the continued litigation of this case, Old Republic, with admitting liability, agrees to pay the date of service May 30, 2008, in accordance with the Texas Workers' Compensation Act and DWC rules. Accordingly, as Old Republic will pay the disputed services, in accordance with the act and rules, there is no dispute pending. Therefore, dismissal is appropriate under DWC Rule 133.307 (e) (3) (A)."

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 30, 2008	99212	$52.62	$0.00
May 30, 2008	97110 x 4 units	$152.72	$152.72
May 30, 2008	97140 x 2 units	$70.74	$70.74
May 30, 2008	97112	$39.61	$39.61
TOTAL		$315.69	$263.07

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 procedure for Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
3. 28 Texas Administrative Code §134.203 sets out the medical fee guidelines for professional medical services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - U – Unnecessary medical treatment or service.
   - 38 – Services not provided or authorized by designated (network/primary care) providers.

Issues

1. Did the insurance carrier issue payments for the disputed charges?
2. Did the requestor file for dispute resolution in accordance with 28 Texas Administrative Code §133.307 for CPT code 99212?
3. Did the requestor obtain preauthorization for the physical therapy services in dispute?
4. Did the requestor bill in conflict with the NCCI edits?
5. Is the requestor entitled to reimbursement?

Findings

1. The division contacted Brenda with Dr. Dipti Patel's office to confirm receipt of payment for date of service May 30, 2008. The requestor indicated that no payments have been received for disputed date of service. As a result, the division will complete the review for the services in dispute.
2. Per 28 Texas Administrative Code §133.307 "(c) Requests. Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division (2) Provider Request. The provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include: (D) when applicable, a copy of the final decision regarding compensability, extent of injury, liability and/or medical necessity for the health care related to the dispute."

   Per 28 Texas Administrative Code §133.307 "(e) MDR Action. The Division will review the completed request and response to determine appropriate MDR action. (3) Dismissal. The Division may dismiss a request for medical fee dispute resolution if (G) the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). . ."

   The requestor seeks resolution for CPT code 99212 denied by the insurance carrier with denial reason code "U – Unnecessary medical treatment or service." The requestor did not submit documentation to support that the issue of unnecessary medical was resolved prior to the submission of the MDR request, as a result, CPT code 99212 rendered on May 30, 2008 is ineligible for review by the Medical Fee Dispute Resolution Section. Reimbursement cannot be recommended.
3. Per 28 Texas Administrative Code §134.600 "(c)The carrier is liable for all reasonable and necessary medical costs relating to the health care: (B)preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care. . ."

   Per 28 Texas Administrative Code §134.600 "(p)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. . ."

   The requestor seeks reimbursement for CPT codes 97110, 97140 and 97112 rendered on May 30, 2008. Review of the preauthorization letter dated May 15, 2008 issued by Sedgwick CMS documents that the requestor obtained preauthorization for CPT codes 97110, 97140 and 97112 with a start date of May 12, 2008 and an end date of May 31, 2008, approval of PT x 3 sessions. The requestor obtained preauthorization for CPT codes 97110, 97140 and 97112 rendered on May 30, 2008, therefore the disputed charges are reviewed pursuant to 28 Texas Administrative Code §134.203 (b).
4. Per 28 Texas Administrative Code § 134.203 "(b) 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."

The division completed NCCI edits to identify potential edit conflicts that would affect reimbursement. The following was identified:

The requestor billed the following CPT codes on May 30, 2008; 99212, 97110, 97112, 97140 and 97032. No edit conflicts were identified therefore the disputed charges are reviewed pursuant to 28 Texas Administrative Code §134.203 (c).

5. Per 28 Texas Administrative Code § 134.203 "(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."

   Per 28 Texas Administrative Code § 134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   The MAR reimbursement for CPT code 97110 is $38.19 x 4 units = a total MAR of $152.75. The requestor seeks $152.72, therefore this amount is recommended.

   The MAR reimbursement for CPT code 97140 is $34.71 x 2 units = a total MAR of $70.74. The requestor is therefore entitled to this amount.

   The MAR reimbursement for CPT code 97112 is $39.61. The requestor is therefore entitled to this amount.

   Review of the submitted documentation finds that the requestor is entitled to a total recommended amount of $263.07, as a result, this amount is recommended for CPT codes 97110, 97140 and 97112.

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 $263.07.

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 $263.07 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	April 11, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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