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
TLC Therapy

Respondent Name
Indemnity Insurance Co of North

MFDR Tracking Number
M4-09-7500-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
April 6, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Preauthorized services billed appropriately."

Amount in Dispute: $506.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medical bill in question was reimbursed pursuant to a private contractual fee arrangement."

Response Submitted by: Downs & Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 25 – July 25, 2008	Physical therapy services	$506.84	$472.59

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 §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – Charges exceed your contracted/legislated fee arrangement
   - BL – Any network reduction is in accordance with the Focus Healthcare Mgmt Inc. Contract
   - 19 – Precertification/authorization notification absent
   - 18 – Duplicate claim/service

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Did the requestor support additional payment is due?

3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT," and BL – "REDUCTION IS IN ACCORDANCE WITH THE FOCUS/FIRST HEALTH CARE INC. CONTRACT." Review of the submitted information found on pages 15 – 16 where the name of the health care provider that was notified of Division required information was the word "Error". This documentation is insufficient to show compliance. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. The carrier denied the disputed services as19 – "Precertification/authorization notification absent". Review of the submitted documentation finds;
    a) Request from TLC Therapy dated, June 10, 2008 for 97110 Therapeutic Exercises (1 to 8 units), 97032 Attended Electrical Stimulation (1 unit), and 97140-59 Manual Therapy (1 to 3 units depending on injury and necessity).
    b) Document from Rebecca Stacey of Gallagher Bassett stating, "I am approving the Physical therapy for 3 x a week for 3 weeks for the Rt Wlbow.)

    There are no limits specified in the adjustor's correspondence. Therefore, the carrier's denial is not supported. The disputed services will be reviewed per applicable rules and fee guidelines.
3. Per 28 Texas Administrative Code §134.203(c) 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 date of service yearly conversion factor".

Date of Service	CPT Code	Amount billed	Units	MAR (TDI-DWC Conversion Factor / Medicare Conversion Factor x Non-Facility Price = MAR	Carrier Paid
June 25, 2008	97110	36.00	1	(52.83/ 38.087) x 25.70 = 35.65	34.25
June 26, 2008	97110	36.00	1	(52.83/ 38.087) x 25.70 = 35.65	0.00
June 26, 2008	97140	34.00	1	(52.83/ 38.087) x 23.86 = 33.10	0.00
June 30, 2008	97110	36.00	1	(52.83/ 38.087) x 25.70 = 35.65	0.00
June 30, 2008	97110	36.00	1	(52.83/ 38.087) x 25.70 = 35.65	0.00
July 14, 2008	97110	36.00	1	(52.83/ 38.087) x 25.70 = 35.65	0.00
July 14, 2008	97110	36.00	1	(52.83/ 38.087) x 25.70 = 35.65	0.00
July 21, 2008	97110	36.00	1	(52.83/ 38.087) x 25.70 = 35.65	0.00
July 21, 2008	97110	36.00	1	(52.83/ 38.087) x 25.70 = 35.65	0.00
July 21, 2008	97140	34.00	1	(52.83/ 38.087) x 23.86 = 33.10	0.00
July 21, 2008	97140	34.00	1	(52.83/ 38.087) x 23.86 = 33.10	0.00
July 23, 2008	97032	21.00	1	(52.83/ 38.087) x 14.77 = 20.49	0.00
July 25, 2008	97110	36.00	1	(52.83/ 38.087) x 25.70 = 35.65	0.00
June 30, 2008	97140	34.00	1	(52.83/ 38.087) x 23.86 = 33.10	0.00
June 30, 2008	97140	34.00	1	(52.83/ 38.087) x 23.86 = 33.10	0.00
Total		$515.00		$506.84	$34.25

4. The maximum allowable reimbursement is $506.84 less $34.25 previously paid by the carrier leaving a remaining balance of $472.59. This amount is due to the provider.

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 $472.59.

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 $472.59 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		October 28, 2014
Signature	Medical Fee Dispute Resolution Officer	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.