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 and Address

LYNNETTE ORRICK DC
6660 AIRLINE DRIVE
HOUSTON TX 77076

Respondent Name
AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-09-9802-01

MFDR Date Received
JUNE 26, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility is NOT part of any Networks. Dr. Orrick has NOT been a part of her prev. employer of Houston Spine & Rehab. since 4/21/08. In addition, our facility tax id #...is not affiliated w/Houston Spine Rehabilitation."

Amount in Dispute: $1,463.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier requests the Division review Requestor's claim under its general obligations to adjudicate disputes in accordance with relevant statutory provisions."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 24, 2008 September 26, 2008 September 29, 2008 October 1, 2008 October 3, 2008	Office Visit – CPT Code 99212 X1 (5 Total Units Billed for Dates of Service)	$35.79 $28.26 $52.62 $35.79 $52.62 $205.08	$205.08
September 24, 2008 September 26, 2008 September 29, 2008 October 1, 2008 October 3, 2008	Physical Therapy – CPT Code 97110 X4 (20 Total Units Billed for Dates of Service)	$115.56 $120.22 $152.72 $116.10 $94.87 $599.47	$599.47
September 24, 2008 September 26, 2008 September 29, 2008 October 1, 2008 October 3, 2008	Physical Therapy – CPT Code 97140 X2 (10 Total Units Billed for Dates of Service)	$59.43 $55.70 $13.02 $48.12 $43.94 $220.21	$220.21
September 24, 2008 September 26, 2008	Physical Therapy – CPT Code 97112 X1 (5 Total Units Billed for Dates of Service)	$26.95 $31.19	$147.45

September 29, 2008 October 1, 2008 October 3, 2008		$12.33 $37.72 $39.26 $147.45	
September 24, 2008 September 26, 2008 September 29, 2008 October 1, 2008 October 3, 2008	Physical Therapy – CPT Code 97032-GP X1 (5 Total Units Billed for Dates of Service)	$14.97 $17.33 $22.01 $14.97 $22.01 $91.29	$91.29
October 6, 2008	Physical Therapy – CPT Code 97110	$152.72	$0.00
October 6, 2008	Physical Therapy – CPT Code 97140	$36.02	$0.00
October 6, 2008	Physical Therapy – CPT Code 97112	$7.29	$0.00
October 6, 2008	Physical Therapy – CPT Code 97032-GP	$4.05	$0.00
TOTAL		$1,463.58	$1,263.50

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 a medical fee dispute.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §133.4, effective July 27, 2008, requires the insurance carrier to notify providers of contractual agreements for informal and voluntary networks.
4. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 45-Charges exceed your contracted/legislated fee arrangement.
   - 663-Reimbursement has been calculated according to the state fee schedule guidelines.
   - 19-(197)-Precertification/authorization/notification absent.

Issues

1. Does the documentation support notification requirements in accordance with 28 Texas Administrative Code §133.4?
2. Is the requestor entitled to reimbursement for services rendered September 24, 2008 through October 3, 2008?
3. Does a preauthorization issue exist for date of service October 6, 2008?

Findings

1. 28 Texas Administrative Code §133.4(g) states "Noncompliance. The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:
   (1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or

   (2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115."

   On October 13, 2010, the Division requested a copy of the written notification to the health care provider pursuant to 28 Texas Administrative Code §133.4. No documentation was provided to sufficiently support that the respondent notified the requestor of the contracted fee negotiation in accordance with 28 Texas Administrative Code §133.4(g).

2. The respondent reduced the amount of reimbursement for the disputed services rendered September 24, 2008 through October 3, 2008 based upon reason code "45." Based upon the findings above and the submitted documentation, the Division finds that the respondent has not supported the reduction based upon reason code "45." As a result, additional reimbursement is recommended for these services.

   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).

   The 2008 DWC conversion factor for this service is 52.83.

   The Medicare Conversion Factor is 38.087

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 77090, which is located in Houston, Texas.

   Using the above formula, the Division finds the following:

Code	Medicare Participating Amount for Locality Houston, TX	MAR X No. of Units Billed for DDOS	Total Paid	Total Due (Difference between MAR and total Paid or Lesser Amount Requested)
99212	$37.94	$52.63 X 5 = $263.13	$58.02	$205.08
97110	$27.53	$38.19 X 20 = $763.73	$164.13	$599.47
97140	$25.50	$35.37 X 10 = $353.71	$133.49	$220.21
97112	$28.56	$39.62 X 5 = $198.08	$50.60	$147.45
97032	$15.87	$22.01 X 5 = $110.07	$18.76	$91.29

3. According to the submitted explanation of benefits, the respondent denied reimbursement for services rendered on October 6, 2006 based upon reason code "19-(197)."

   Per 28 Texas Administrative Code §134.600(p)(5)(A) the non-emergency healthcare that requires 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: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
   (i) Modalities, both supervised and constant attendance;

   (ii) Therapeutic procedures, excluding work hardening and work conditioning.

   Review of the submitted documentation finds that on September 11, 2008, the requestor obtained preauthorization for 2 visits of physical therapy services. The Division reviewed the submitted documentation and finds that physical therapy services were rendered on all six disputed dates of service. These dates of service were after the September 11, 2008 preauthorization report. Because the respondent only denied reimbursement for services rendered on October 6, 2008 based upon a lack of preauthorization and there was

no proof that preauthorization was obtained for October 6, 2008, reimbursement is not recommended.

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 $1,263.50.

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 $1,263.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		03/28/2014
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.