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
DOWNTOWN PERFORMANCE MEDICAL CENTER

Respondent Name
WORK FIRST CASUALTY COMPANY

MFDR Tracking Number
M4-09-9933-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 4, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are not willing to accept the payments below Texas WC State Fee Schedule on this account and are requesting your assistance in having these bills processed and reimbursed according to the Texas State Fee Guideline."

Amount in Dispute: $1,078.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 3, 2008 to June 24, 2008	Physical Therapy Services	$1,078.92	$1,002.90

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 §134.1 sets forth general provisions related to medical reimbursement.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE FOCUS/AETNA WORKERS COMP LLC ACCESS CONTRACT. FOR QUESTIONS REGARDING NETWORK REDUCTIONS, PLEASE CALL 1-800-243-2336.
   - THE MAXIMUM UNIT VALUE ALLOWED PER DOS FOR BILLS THAT INCLUDE ANY TREATMENT IDENTIFIED UNDER 97002, 97004, 97010-97799 (EXCLUDING 97545 AND/OR 97546) & 98925-98943 FOR PHYSICIAN, CHIRO, PT, PTA, PT OR OTA IS 16 UNITS.
   - REIMBURSEMENT IS BASED UPON THE MAXIMUM ALLOWABLE FEE FOR THIS PROCEDURE BASED UPON THE NEVADA MEDICAL FEE SCHEDULE, OR IF ONE IS NOT SPECIFIED, USUAL, CUSTOMARY & REASONABLE RATE FOR THIS GEOGRAPHIC (ZIP CODE) AREA.

Issues

1. Were the services in dispute timely submitted to the Division for medical fee dispute resolution?
2. Did the insurance carrier submit a response for consideration in this dispute?
3. Are the disputed services subject to a contractual fee agreement between the parties to this dispute?
4. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
5. What is the recommended payment amount for the services in dispute?
6. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1), effective May 25, 2008, 33 *Texas Register* 3954, states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The request for dispute resolution of services rendered on date of service June 3, 2008 was received by the Division on June 4, 2009. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution with respect to service date June 3, 3008. Those disputed services will not be considered. However, the request for dispute resolution of services rendered from June 4 to June 24, 2008 was submitted in accordance with the timely filing requirements of §133.307(c)(1); therefore, these services will be considered in this review.
2. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was signed received by the insurance carrier's Austin representative. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
3. The insurance carrier denied disputed services with the explanation "ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE FOCUS/AETNA WORKERS COMP LLC ACCESS CONTRACT. FOR QUESTIONS REGARDING NETWORK REDUCTIONS, PLEASE CALL 1-800-243-2336." No documentation was found to support that the disputed services are subject to a negotiated or contracted amount that complies with Labor Code §413.011. The Division concludes that the services are not subject to a contractual fee reduction. Reimbursement will therefore be considered per applicable division rules and fee guidelines
4. The insurance carrier denied disputed services with the following explanations: "THE MAXIMUM UNIT VALUE ALLOWED PER DOS FOR BILLS THAT INCLUDE ANY TREATMENT IDENTIFIED UNDER 97002, 97004, 97010-97799 (EXCLUDING 97545 AND/OR 97546) & 98925-98943 FOR PHYSICIAN, CHIRO, PT, PTA, PT OR OTA IS 16 UNITS" and "REIMBURSEMENT IS BASED UPON THE MAXIMUM ALLOWABLE FEE FOR THIS PROCEDURE BASED UPON THE NEVADA MEDICAL FEE SCHEDULE, OR IF ONE IS NOT SPECIFIED, USUAL, CUSTOMARY & REASONABLE RATE FOR THIS GEOGRAPHIC (ZIP CODE) AREA." No documentation was presented to support these denial or reduction reasons. Reimbursement will therefore be considered per applicable division rules and fee guidelines.
5. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c) requires that "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." Reimbursement for the disputed services is calculated as follows:
   - Procedure code 97110, service date June 4, 2008, has a Medicare payment rate of $27.53. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83, results in a MAR of $38.19. This amount multiplied by the 3 units in dispute results in a recommended reimbursement of $114.57.
   - Procedure code 97110, service date June 6, 2008, has a Medicare payment rate of $27.53. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83, results in a MAR of $38.19. This amount multiplied by the 2 units in dispute results in a recommended reimbursement of $76.38.
   - Procedure code 97110, service date June 11, 2008, has a Medicare payment rate of $27.53. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of

52.83, results in a MAR of $38.19. This amount multiplied by 4 units results in a recommended reimbursement of $152.76.

- Procedure code 97110, service date June 13, 2008, has a Medicare payment rate of $27.53. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83, results in a MAR of $38.19. This amount multiplied by 4 units results in a recommended reimbursement of $152.76.
- Procedure code 97110, service date June 18, 2008, has a Medicare payment rate of $27.53. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83, results in a MAR of $38.19. This amount multiplied by 4 units results in a recommended reimbursement of $152.76.
- Procedure code 97110, service date June 20, 2008, has a Medicare payment rate of $27.53. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83, results in a MAR of $38.19. This amount multiplied by the 3 units in dispute results in a recommended reimbursement of $114.57.
- Procedure code 97110, service date June 23, 2008, has a Medicare payment rate of $27.53. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83, results in a MAR of $38.19. This amount multiplied by 4 units results in a recommended reimbursement of $152.76.
- Procedure code 97110, service date June 24, 2008, has a Medicare payment rate of $27.53. This amount divided by the Medicare conversion factor of 38.087 and multiplied by the Division conversion factor of 52.83, results in a MAR of $38.19. This amount multiplied by 4 units results in a recommended reimbursement of $152.76.

6. The total recommended payment for the services in dispute is $1,069.32. This amount less the amount previously paid by the insurance carrier of $66.42 leaves an amount due to the requestor of $1,002.90. This amount is 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 $1,002.90.

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 $1,002.90 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	June 27, 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.