**Texas Department of Insurance, Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

Requestor's Name and Address:

Southeast Health Services
P.O. Box 453062
Garland, TX 75045

MFDR Tracking #: M4-05-A882-01

Respondent Name and Box #:

Liberty Mutual Fire Insurance
Rep Box#: 28

## PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMEN

Requestor's Position Summary as taken from the Table of Disputed Services: "Denied as Global"

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $171.87
3. CMS 1500s
4. EOBs
5. Updated Table of Disputed Services

## PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "We base our payments on the Texas Fee Guidelines and the Texas Workers' Compensation Acts and Rules."

Principal Documentation:

1. Response to DWC 60

## PART IV: SUMMARY OF FINDINGS

| Eligible Dates of Service (DOS) | CPT Codes | Denial Codes | Part V Reference | Amount Ordered |
|---|---|---|---|---|
| 08/24/04 | 97140-59 | X322(N) | 1, 5 | $34.13 |
| 08/24/04 and 8/27/04 | 98943 | X815(G) | 2 | Per Rule 134.202(c)(6) |
| 09/27/04 | 97140-59 | X206(R), X815(G) | 3, 5 | $34.13 |
| 09/27/04 | 98943 | X206(R), X322(N) | 4 | Per Rule 134.202(c)(6) |
| **Total Due:** | | | | $68.26 |

[redacted]

## PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

Requestor submitted Updated Table of Disputed Services from Requestor which removed several CPT codes from original disputed Dates of Service 08/18/04 through 09/27/04 totaling $924.51 as paid.

1. For DOS 08/24/04 and CPT code **97140-59**, these services were denied by the Respondent with reason code "X322 – Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge." CPT Code **97140** is a component of CPT Code **98941** billed on the same day. CPT code **97140** is also mutually exclusive to CPT code **97012** also billed on the same day. A modifier is allowed in order to differentiate between services; separate payment for the services may be considered justifiable if a modifier is used appropriately. The Requestor billed with modifier -59. Therefore, reimbursement at MAR of $34.13 (based on $27.30 x 125%) is recommended to Requestor.
2. For DOS 08/24/04 and DOS 08/27/07 CPT code **98943**, these services were denied by the Respondent with reason code "X815 – G – This procedure is incidental to the primary procedure, and does not warrant separate reimbursement." CPT Code **98943** is not global to any other service performed on DOS 08/24/04 and 08/27/04 per CCI edits. CPT code **98943** is reimbursable to Requestor per Rule 134.202(c)(6) which states that carrier shall "..assign a relative value, which may be based on nationally recognized published relative value studies, published [DWC] medical dispute decisions, and values assigned for services involving similar work and resource commitments."
3. For DOS 09/27/04 and CPT code **97140-59**, these services were initially denied by the Respondent with reason code "X206 – The service(s) is for a condition(s) which is not related to the covered work related injury. For reconsideration of charges, please submit documentation to support the relatedness of services rendered to the work related injury." Upon reconsideration, the denial was changed to "X815 – G - This procedure is incidental to the primary procedure, and does not warrant separate reimbursement." CPT Code **97140-59** denial for "X206" is not valid as there are no compensability, extent of injury, or liability issues on this claim per adjuster. CPT Code **97140** is a component of CPT Code **98940** billed on the same day. A modifier is allowed in order to differentiate between services; separate payment for the services may be considered justifiable if a modifier is used appropriately. The Requestor billed with modifier -59. Therefore, reimbursement at MAR of $34.13 (based on $27.30 x 125%) is recommended to Requestor.
4. For DOS 09/27/04 CPT code **98943**, these services were initially denied by the Respondent with reason code "X206 – The service(s) is for a condition(s) which is not related to the covered work related injury. For reconsideration of charges, please submit documentation to support the relatedness of services rendered to the work related injury." Upon reconsideration, the denial was changed to "X322 – N - X322 – Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge." There are no compensability, extent of injury, or liability issues on this claim per adjuster, therefore a denial of X206 is not valid. Addressing the denial for insufficient documentation, "X-322", documentation attached to CMS-1500s indicates extra-spinal manipulations were performed using CPT code **98943**. CPT code **98943** is reimbursable to Requestor per Rule 134.202(c)(6) which states that carrier shall "..assign a relative value, which may be based on nationally recognized published relative value studies, published [DWC] medical dispute decisions, and values assigned for services involving similar work and resource commitments."
5. Per review of Box 32 on CMS-1500, zip code 75217 is located in Dallas County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

## PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, Section. 134.202, Section 134.202)
Texas Government Code, Chapter 2001, Subchapter G

## PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $68.26 for dates of service 08/24/04 and 09/27/04 (CPT code 97140-59) and per Rule 134.202(c)(6) for dates of 08/24/04, 08/27/04, and 09/27/04 (CPT code 98943) plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

**ORDER**

| [redacted] | [redacted] | 10/26/07 |
|---|---|---|
| Authorized Signature | Medical Fee Dispute Resolution Officer | Date |

**PART VIII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (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. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

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