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

NISAL CORP
PO BOX 24809
HOUSTON TX 77029

Respondent Name
INDEMNITY INSURANCE CO OF NORTH

Carrier's Austin Representative
Box Number 15

MFDR Tracking Number
M4-11-3081-01

MFDR Date Received
May 12, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier issued a denial which reads: The billed procedure code requires a modifier. Please re-bill with the correct modifier. We have since corrected this problem and re faxed this claim to the carrier. They promptly issued the same denial."

Amount in Dispute: $137.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider billed CPT code 97001. Per the Medical coding edits for physical therapy services (attached), this code requires that the Provider utilize one of the following modifiers to delineate the type of therapy evaluation provided: -GP, -GO, or –GN. The Provider's billing does not reflect the utilization of any of the required modifiers; therefore the Provider's therapy billing was not properly coded. As the Provider failed to properly code the billing submitted to the Carrier, the Provider is not entitled to reimbursement for the billed services."

Response Submitted by: William E. Weldon

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 27, 2010	97001	$137.00	$0.00

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 fee guideline for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - T019 – (16) Claim/service lacks information needed for adjudication. The billed procedure code requires a modifier. Please re-bill using correct modifier.
   - TXM9 – (4) The procedure code is inconsistent with the modifier used or a required modifier is missing. Reimbursement is made based on Medicare coding, billing and reimbursement methodologies.

Issues

1. Did the requestor append the appropriate modifier to CPT code 97001 and is the requestor entitled to reimbursement?

Findings

1. 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."

   Review of the EOB dated February 11, 2011, documents that the insurance carrier reviewed CPT code 97001 and denied the service with denial reason code "TXM9 – (4) The procedure code is inconsistent with the modifier used or a required modifier is missing. Reimbursement is made based on Medicare coding, billing and reimbursement methodologies."

   Review of the CMS-1500 indicates that the requestor appended modifier -59 to the reconsideration bill. Review of the EOB dated March 9, 2011, documents that the insurance carrier reviewed CPT code 97001-59 and denied the service with denial reason code "TXM9 – (4) The procedure code is inconsistent with the modifier used or a required modifier is missing. Reimbursement is made based on Medicare coding, billing and reimbursement methodologies."

   Review of the EOB dated March 14, 2011, documents that the insurance carrier reviewed CPT code 97001 and denied the service with denial reason code "T019 – (16) Claim/service lacks information needed for adjudication. The billed procedure code requires a modifier. Please re-bill using correct modifier."

   CPT code 97001 is defined in the AMA CPT Code Book as "Physical therapy evaluation." Review of the Medicare Claims Processing Manual Chapter 5, Requirements – Professional Claims, states in pertinent part, "Claims containing any of the "always therapy" codes should have one of the therapy modifiers appended (GN, GO, GP). The CPT code in dispute is listed as an "always therapy" code. The disputed code was not billed with the required modifier, as a result, reimbursement cannot be recommended for CPT code 97001.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		January 23, 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.