



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

IMAGE MEDICAL CENTER

Respondent Name

WAL MART ASSOCIATES INC

MFDR Tracking Number

M4-13-2613-01

Carrier's Austin Representative Box

Number 53

MFDR Date Received

JUNE 11, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The initial preauthorization request was denied; however, the sessions were in fact approved after an appeal, review #355622. 6 chiropractic sessions between 1/23/13-3/25/13 were certified. Therefore, payment should be made to our facility.."

Amount in Dispute: \$2,117.64

RESPONDENT'S POSITION SUMMARY

Respondent's Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on June 18, 2013. 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.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 18, 2013 through February 27, 2013	97140 AND 97110	\$2,117.64	\$293.34

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the medical fee guidelines for professional medical services.
- 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 39- Services denied at the time authorization/pre-certification was requested.
 - 5057- The healthcare provider requested preauthorization; however, the insurance carrier denied approval (according to chapter 134).

- 193- Original payment decision is being maintained. This claim was processed properly the first time.
- 5081- Reduction or denial of payment resulting after reconsideration was completed.

Issues

1. What are the AMA CPT Code definitions for 97110 and 97140?
2. Did the requestor obtain authorization for CPT codes 97110 and 97140?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 (b)(1) "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."

The requestor disputes denial of CPT code 97110 rendered on February 18, 2013 through February 27, 2013. The AMA CPT Code book defines CPT 97110 as follows: "Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility."

The requestor billed CPT code 97140 for services rendered on February 18, 2013 through February 27, 2013. The AMA CPT Code book defines CPT code 97140 as follows: "Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes."

2. Per Texas Administrative Code §134.600, "(p)Non-emergency health care requiring 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 preauthorization letter issued by Ad Management dated February 13, 2013 states in relevant part "1. Recommended prospective request for 6 chiropractic manipulation sessions between 1/23/2013 and 3/25/2013 be certified."

The requestor submitted insufficient documentation to support that preauthorization was obtained for CPT code 97110. As a result, reimbursement cannot be recommended for this code.

The requestor submitted sufficient documentation to support that preauthorization was obtained for CPT code 97140. As a result reimbursement is recommended pursuant to 28 Texas Administrative Code §134.203.

3. Per 28 Texas Administrative Code §134.203 "(c) 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 MAR reimbursement for CPT code 97140 is: \$48.89/per unit x 6= \$293.34.

Therefore, for the reasons noted above, reimbursement is recommended for the disputed CPT code 97140 rendered on February 18, 2013 through February 27, 2013.

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 \$293.34.

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 \$293.34 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July 11, 2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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