TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS & DECISION

GENERAL INFORMATION

Requestor Name and Address
ELITE HEALTHCARE FORT WORTH
PO BOX 1353
FRISCO TX 75034

[redacted]

Respondent Name
INDEMNITY INSURANCE CO

Carrier's Austin Representative
Box Number 15

MFDR Tracking Number
M4-13-3280

MFDR Date Received
AUGUST 12, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am resubmitting the claim for payment for the following reasons: THIS IS NOT A CUPLICATE CLAIM/SERVICE. This is an approved case and all other dates of service have been paid in full. Claims before and after these dates of service have been paid in full. This patient has had 56 dates of service and our office has received 46 checks from insurance company. Attached claims are the only claims that have not been paid, either in full or at all...."

Amount in Dispute: $434.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position 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 August 20, 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
April 5, 2012	CPT Code 97002	$64.76	$0.00
July 26, 2012 through May 14, 2013	Professional Services	$369.57	$0.00

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 guidelines for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative.
   - 910-053 – Extent on injury not finally adjudicated.

Issues

1. Is CPT Code 97002 bundled to other services rendered on April 5, 2012?
2. What are the denial reason(s) raised by the insurance carrier during the bill review process for dates of service April 5, 2012 through May 14, 2013?
3. Did the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of Compensability, Extent of Injury and/or Liability (CEL)?
4. Are the disputed services eligible for review by Medical Fee Dispute Resolution?

Findings

1. In accordance with 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 services for date of service April 5, 2012 finds:
   - CPT Code 97002 was billed with CPT Codes 97112 and 97110. According to 28 Texas Administrative Code §134.203(b)(1) these codes may not be billed together unless a modifier is allowed and supported by documentation. The correct modifier was not appended; therefore, reimbursement is not recommended.
2. The medical fee dispute referenced above contains information/documentation that indicates that there are **unresolved** issues of extent of injury for the same service(s) for which there is a medical fee dispute. Review of the EOBs presented by the both the requestor and respondent indicate denial reason code "236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative" and "910-053 – Extent on injury not finally adjudicated."

3. **Unresolved extent-of-injury dispute:** The medical fee dispute referenced above contains unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical billing process.

   Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent of injury dispute for the claim. 28 Texas Administrative Code § 133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

Extent-of-injury dispute process: The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of CEL, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a courtesy to the requestor, instructions on how to file for resolution of the extent of injury issue are attached.

The division finds that due to the unresolved CEL issues, the medical fee dispute request for dates of service July 26, 2012 through May 14, 2013 is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.307(c)(1)(B).

Dismissal provisions: 28 Texas Administrative Code § 133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code § 133.307. 28 Texas Administrative Code § 133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the extent-of-injury dispute.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This decision is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered. The Division finds that dates of service July 26, 2012 through May 14, 2014 are not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307; however, date of service April 5, 2012 is eligible for medical fee dispute resolution and a review of all the evidence presented by the parties for this date of service was considered.

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

Signature	Marguerite Foster Medical Fee Dispute Resolution Officer	September 24, 2015 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.