



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Texas Alliance Medical Group

**Respondent Name**

Texas Mutual Insurance

**MFDR Tracking Number**

M4-14-2384-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

April 1, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Initially, several service codes were billed for this patient 97140 (denied; 97110, 97012, G0283 which Manual Therapy and Mechanical Traction can be considered the same procedure depending on the modality applied in this case a Mechanical Traction table was used and Chiropractor physically applied and adjustment to patient prior to Physical Therapy performed by patient, which was medically necessary for patients recovery process, and according to the guidelines as long as there is a justifiable medical explanation."

**Amount in Dispute:** \$702.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Texas Mutual reviewed the billing and attached documentation. From that review it determined payment of the code is not allowed per NCCI edits."

**Response Submitted by:** Texas Mutual

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15 – September 6, 2013	97140	\$702.00	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 434 – This procedure code is not reimbursed when billed with another mutually exclusive procedure code on the same date of service.
  - 193 – Original payment decision is being maintained.

**Issues**

- 1. Did the requestor support services in dispute were separate and distinct?
- 2. Is the requestor entitled to reimbursement?

**Findings**

- 1. The carrier denied the disputed service as, 434 – “This procedure code is not reimbursed when billed with another mutually exclusive procedure code on the same date of service.” 28 Texas Labor Code §134.203(b) states, “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;... and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules

Review of the National Correct Coding Initiatives Edits, [www.cms.hhs.gov](http://www.cms.hhs.gov) finds a conflict between 97140 and 97110. A modifier in to support documentation exists to detail separate and distinct procedure could be allowed. The submitted medical claim contained no modifier nor did documentation support separate service. The carrier’s denial is supported.

- 2. Submitted medical documentation did not support separate payment for disputed services.

**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**

Signature	Medical Fee Dispute Resolution Officer	July 10, 2014 Date
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**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.**