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
Cypress Fairbanks Medical

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-14-3443-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 18, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "You have denied his claim based on the modifier. Please see the enclosed information. "

Amount in Dispute: $120.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the provider would need to also bill a G code with the 97001. Denial is appropriate."

Response Submitted by: Gallagher Bassett, 11940 Jollyville Road, Ste 210N, Austin, TX 78759

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 30, 2013	97001 GP	$120.99	$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 reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
   - BL – This bill is a reconsideration of a previously reviewed bill

Issues

1. Did the requestor support disputed services payable as submitted?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as, 4 – "The procedure code is inconsistent with the modifier used or a required modifier is missing." 28 Texas Labor Code §134.203(b) states in pertinent part, "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." The Medicare Claims Processing Manual found at www.cms.hhs.gov, Chapter 4, Subchapter 5, states in pertinent parts, "10.6 - Functional Reporting. Application of New Coding Requirements. This functional data reporting and collection system is effective for therapy services with dates of service on and after January 1, 2013…" "(G) …Functional reporting using the G-codes and corresponding severity modifiers is required reporting on specified therapy claims. Specifically, they are required on claims: • At the outset of a therapy episode of care (i.e., on the claim for the date of service (DOS) of the initial therapy service); • At least once every 10 treatment days, which corresponds with the progress reporting period; • When an evaluative procedure, including a re-evaluative one, (HCPCS/CPT codes 92521, 92522, 92523, 92524, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004) is furnished and billed;" The carrier's denial is supported.
2. The Division finds requirements of 28 Texas Labor Code §134.203(b) is not met. No additional payment can be recommended.

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	October , 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.