



**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**

West Texas Rehab Center

**Respondent Name**

New Hampshire Insurance Company

**MFDR Tracking Number**

M4-15-1554-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

January 27, 2015

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We have a contracted day rate with Medrisk for \$90.00 per day. We were not paid according to our contracted rate. I have faxed and mailed in appeals numerous times. As you can see by the return faxes from Medrisk that they have acknowledged receipt of these appeals and have sent a form stating that we need to allow more time for processing. These forms were received on 7/30/14. Since then no further communication or payment has been received for these appeals.

I feel in good faith we should be paid our contracted rate as it is well below what our charges are or what we would get paid if we went by the fee schedule."

**Amount in Dispute:** \$183.62

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "This is a medical fee dispute concerning service dates March 3, 2014 to March 20, 2014..."

The reimbursements for these services were reduced based upon a contracted amount. Attached are the EOBs showing the adjustment. Carrier has submitted the billing for additional review and will supplement this response with the results of that re-audit."

Supplemental response, dated February 23, 2015: "Carrier has previously responded to this dispute on 2/18/2015. Please see the attached copy of the contract between Med Risk and West Texas Rehab Center.

Carrier maintains its position as outlined in the original response."

**Response Submitted by:** Flahive, Ogden & Latson

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 3 – 20, 2014	Physical Therapy	\$183.62	\$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 §133.240 sets out the procedures for payment or denial of medical bills.
3. 28 Texas Administrative Code §134.203 sets out the fee schedule for billing and reimbursing professional medical services.
4. Texas Labor Code §413.011 defines how fee guidelines may be enacted.
5. Texas Labor Code §413.0115 defines networks within the workers' compensation system.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 45 – Charges exceed your contracted/legislated fee arrangement
  - 16 – Claim/service lacks information which is needed for adjudication
  - W1 – Workers' Compensation State Fee Schedule Adjustment
  - AC – The payment for this service should be established
  - UL – An unlisted procedure or service requires identification
  - MV – Reviews, dated and signed, of the treatment plan b
  - W5 – Adjustment amount represents prior underpayment
  - ZR – Not defined as required in 28 Texas Administrative Code §133.240

## **Issues**

1. Does a network issue exist for the disputed services?
2. Is the requestor entitled to reimbursement?

## **Findings**

1. The requestor seeks reimbursement, claiming the contracted rate has not been paid for the disputed services. The insurance carrier disagrees and states that they have paid according to a contract between Med Risk and the requestor. A review of the networks certified by the Division of Workers' Compensation does not find that Med Risk is a certified network allowed to contract for rates within the workers' compensation system in Texas. Texas Labor Code §413.011 (d-4) states, "Notwithstanding this section or any other provision of this title, an insurance carrier, an insurance carrier's authorized agent, or a network certified under Chapter 1305, Insurance Code, arranging for non-network services or out-of-network services under Section 1305.006, Insurance Code, may continue to contract with a health care provider to secure health care for an injured employee for fees that exceed the fees adopted by the division under this section." The statutes in this section that applied to the formation of informal and voluntary networks expired January 1, 2011 with 80(R) HB 473. Further, Texas Labor Code §413.0115 (b) states, "Not later than January 1, 2011, each informal network or voluntary network must be certified as a workers' compensation health care network under Chapter 1305, Insurance Code." Because the contract submitted is not certified under Chapter 1305, Insurance Code and the fees involved are below the fee schedule defined by 28 Texas Administrative Code §134.203, the network contract will not be considered. The dispute will be based on 28 Texas Administrative Code §134.203 and other applicable rules.
2. 28 Texas Administrative Code §134.203(b)(1) 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..."

For date of service March 3, 2014, the dispute involves physical therapy CPT code 97140-GO-59. The other codes billed for this date of service are CPT code 97022 and 97110. As no CCI edits exist with these codes, modifier 59 is unnecessary. 28 Texas Administrative Code §133.307 (c)(2) states, in relevant part, "The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division...The request shall include: (M) a copy of all applicable medical records related to the dates of service in dispute." A review of the submitted documentation does not find the medical records to support this charge. Therefore, no additional reimbursement is recommended for this date of service.

For date of service March 6, 2014, the dispute involves physical therapy CPT code 97140-GO-59. The other codes billed for this date of service are CPT code 97022 and 97110. As no CCI edits exist with these codes, modifier 59 is unnecessary. 28 Texas Administrative Code §133.307 (c)(2) states, in relevant part, "The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division...The request shall include: (M) a copy of all applicable medical records related to the dates of service in dispute." A review of the submitted documentation does not find the medical records to support this charge. Therefore, no additional reimbursement is recommended for this date of service.

For date of service March 10, 2014, the dispute, as stated on the request for Medical Fee Dispute Resolution (MFDR), involves physical therapy CPT code 97039/97022. Review of the submitted documentation finds that the CMS-1500 and explanations of benefits support that CPT code 97039 was billed, but CPT code 97022 was not. CPT code 97039 is not payable under the Medicare Fee Schedule. Therefore, no additional reimbursement is recommended for this date of service.

For date of service March 17, 2014, the dispute, as stated on the request for MFDR, involves physical therapy CPT code 97039/97022. Review of the submitted documentation finds that the CMS-1500 and explanations of benefits support that CPT code 97039 was billed, but CPT code 97022 was not. CPT code 97039 is not payable under the Medicare Fee Schedule. Therefore, no additional reimbursement is recommended for this date of service.

For date of service March 20, 2014, the dispute, as stated on the request for MFDR, involves physical therapy CPT code 97039/97022. Review of the submitted documentation finds that the CMS-1500 and explanations of benefits support that CPT code 97039 was billed, but CPT code 97022 was not. CPT code 97039 is not payable under the Medicare Fee Schedule. Additionally, the dispute for this date of service involves physical therapy CPT code 97110. 28 Texas Administrative Code §133.307 (c)(2) states, in relevant part, "The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division...The request shall include: (M) a copy of all applicable medical records related to the dates of service in dispute." A review of the submitted documentation does not find the medical records to support this charge. Therefore, no additional reimbursement is recommended for this date of service.

**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**

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Signature

Laurie Garnes  
Medical Fee Dispute Resolution Officer

April 9, 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.**