



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

Magnolia Strong Group, Inc.

Respondent Name

Liberty Mutual Fire Insurance

MFDR Tracking Number

M4-15-1857-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

February 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our office received partial payments regarding the aforementioned patient for dates of service 11/17/2014, 11/18/2014, 11/19/2014, and 11/20/2014. CPT code 97532 was denied per CCI Edits. Enclosed you will find the following:

1. The CCI 19.0 Correct Coding Initiative Edits showing that CPT 97532 can be billed with CPT codes 97530 and 97537.
2. A copy of the original claims.
3. Copies of the partial payment EOBs.
4. Copies of EOBs paid correctly by Liberty Mutual."

Amount in Dispute: \$3300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The disputed charges are actually included in additional procedures billed and separate reimbursement is only allowed with a modifier. The modifier -59 was not billed with the disputed code. Our position remains the same and no additional reimbursement is currently being processed."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 17 – 20, 2014	Cognitive therapy (97532)	\$3300.00	\$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

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 fee guidelines for billing and reimbursing professional medical services.
3. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
- 97 – Not defined as required by 28 Texas Administrative Code §133.240. The ASC defines the code as: “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.”
 - MX59 – Per NCCI, the procedure code is denied, as included in a more extensive procedure. Procedure included in 97530.

Issues

1. Are the disputed services bundled per 28 Texas Administrative Code §134.203?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative 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; 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” [emphasis added].

Review of the documentation finds that the disputed CPT Code 97532 was billed with CPT Code 97530 on each date of service in question. Medicare’s CCI Edits for these codes indicate that they may not be billed together without an appropriate modifier. CPT Code 97532 is considered secondary. Documentation does not support that this code was billed with an appropriate modifier for the dates of service in question. Therefore, the disputed services are bundled according to 28 Texas Administrative Code §134.203.

2. Because the disputed services are considered bundled with another code billed on the same dates of service, no further reimbursement is 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

Laurie Garnes
Medical Fee Dispute Resolution Officer

April 28, 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.