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

Respondent Name
Liberty Mutual Insurance

MFDR Tracking Number
M4-15-2014-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
March 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The CCI 19.0 Correct Coding Initiative Edits showing that CPT 97532 can be billed with CPT codes 97530 and 97537."

Amount in Dispute: $1,650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have reviewed dates of service 11/24/14 – 11/26/14 for development cognitive skills and we have determined that no additional is due at this time."

Response Submitted by: Liberty Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 24 – 26, 2014	97532	$1,650.00	$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 reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – NCCI, the procedure code is denied, as included in a more extensive procedure. Procedure included in 97530
   - 193 – Original payment decision is being maintained.

Issues

1. What is the applicable rule pertaining to billing and reimbursement?
2. Is the requestor entitled to reimbursement?

Findings

1. The Carrier denied the disputed service as 97 – "NCCI, the procedure code is denied, as included in a more extensive procedure. Procedure included in 97530". 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; 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 Medicare National Correct Coding Initiatives finds;
    a. Procedure code 97532 has a CCI conflict with procedure code 97530. Use of a modifier supported by documentation would allow an override of the bundled procedure.
    b. The submitted medical claim finds no modifier was submitted with this code.

   The Carrier's denial is supported.
2. Based on the above the Division finds no separate 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

		April 9, 2015
Signature	Medical Fee Dispute Resolution Officer	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.