TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Clinics of North Texas

Respondent Name
Wausau Underwriters Insurance

MFDR Tracking Number
M4-15-2886-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $39.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Hot and cold packs billed as physical therapy with code 97010 are not reimbursable under Medicare. As Texas Division of Workers' Compensation utilizes reimbursement rules and logic they are not reimbursable under Workers' Compensation in the state of Texas. According to Medicare, this code is always bundled, whether or not other codes are billed and should never be separately reimbursed."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 13, 2014 September 16, 2014 September 17, 2014	97010	$39.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – X815 This procedure is incidental to the primary procedure, and does not warrant separate reimbursement
   - 193 – Original payment decision is being maintained

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 97 – X815 "This procedure is incidental to the primary procedure, and does not warrant separate reimbursement." 28 Texas Administrative Code §134.203 (b) requires that "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;" Review of the submitted information finds;

        a. Code in dispute is 97010 which is defined as, "Application of a modality to 1 or more areas; hot or cold pack."

        b. Per CMS Manual System Department of Health & Human Services (DHHS) Pub. 100-04 Medicare Claims Processing Centers for Medicare & Medicaid Services (CMS) Transmittal 42 Date: DECEMBER 8, 2003 CHANGE REQUEST 3005, "****Codes 97010 and 97602 are bundled. They are bundled with any therapy codes. Regardless of whether they are billed alone or in conjunction with another therapy code, never make payment separately for these codes. If billed alone, either code should be denied using the existing EOMB/MSN language. For remittance advice notices, use group code CO and claim adjustment reason code 97 that says: "Payment is included in the allowance for another service/procedure."

    The Division finds the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

2. Provisions of Rule 134.203 that require adherence to Medicare payment policies will not allow separate payment for the services in dispute.

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

		July 16, 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, 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 MFDR 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.