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
Texas Health HEB

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-18-4863-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 13, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note per the NCCI edits this line is not bundled and we show should have processed for payment."

Amount in Dispute: $129.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester billed code 97161GP, on its OPPS bill, without reporting the functional G-code and appropriate modifier."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 13, 2017	97161GP	$129.63	$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 §134.403 sets out the fee guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 246 – This non-payable code is for required reporting only
   - 631 – PT, OT, or SP code present without required non-payable code G code

Issues

1. Are the insurance carrier's reasons for denial of payment supported?

Findings

1. The requestor is seeking reimbursement for code 97161 billed in an outpatient hospital setting for date of service September 13, 2017. The insurance carrier denied disputed services with claim adjustment reason code 246 – "This non-payable code is for required reporting only" and 631 – "PT, OT, or SP code present without required non-payable G code."

   28 Texas Administrative Code §134.403 (d) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

2. Review of the Medicare Claims Processing Manual at www.cms.gov Chapter 5, Section 10.6 - Functional Reporting

   > *This functional data reporting and collection system is effective for therapy services with dates of service on and after January 1, 2013.*
   >
   > *Claims for therapy services furnished on and after July 1, 2013, that do not contain the required functional G-code/modifier information will be returned or rejected, as applicable*.
   >
   > *There are 42 functional G-codes, 14 sets of three codes each. Six of the G-code sets are generally for PT and OT functional limitations and eight sets of G-codes are for SLP functional limitations.*

   The carrier's denial is supported no additional payment 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 19, 2018 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 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. **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.