



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 Alliance

Respondent Name

ACIG Insurance Co

MFDR Tracking Number

M4-19-0180-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

September 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: \$131.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel will maintain the requestor, Texas Health Alliance is not entitled to addition reimbursement for the date of service 5/24/18: CPT 97110 and 97140 based on DWC adopted fee guideline, Medicare payment policies and correct coding initiative (CCI) edits in effect at the time services were provided."

Response Submitted by: Corvel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 24, 2018	97110, 97140	\$131.81	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the guidelines for outpatient hospital services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 236 – This proc or proc/mod combo not compatible
 - R79 – CCI; Standards of Medical/Surgical Practice

Issues

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking additional reimbursement in the amount of \$131.84 for Procedure Codes 97110 and 97140 billed May 24, 2018. The insurance carrier denied as 236 – “This proc or proc/mod combo not compatible.”

28 TAC § 134.403 (b)(3) and (d) states in pertinent parts,

(b)(3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

(d) 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

Review of the submitted medical bill found for the date of service May 24, 2018 the three codes billed were;

- 97760 – Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
- 97110 – Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
- 97140 – Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 min

The Medicare payment policy or National Correct Coding Initiative Edits at <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html> review of the submitted codes and date of service found an edit exists between Code 97660 and 97110/97140. Based on this review, 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

October 16, 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.