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
Dr. Christopher Henn

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-1757-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
November 27, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We only received $495.30 there is still an outstanding balance of $1,299.70 that was billed and not paid on."

Amount in Dispute: $1,330.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No payment is due for physical therapy provided on the dates above per Rule 134.600(p)(C)(i)(ii). Texas Mutual found no evidence in its claim file or the DWC60 packet that meet the exception requirement under (p)(C)(i)(ii). Texas Mutual will pay the MAR for codes G0283 AND 99455."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 14, 2018 through September 28, 2018	A4595, G0283, 97035, 97140, G0283, 97035, 97140, 99455	$1,330.00	$23.53

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 §134.600 sets out the requirements for prior authorization
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §134.204 sets out the reimbursement guidelines for workers' compensation

specific services

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 197 – Precertification/authorization/notification absent
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 217 – The value of this procedure is included in the value of another procedure performed on this date

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 requestor is seeking reimbursement for professional medical services rendered from September 14, 2018 through September 28, 2018. The insurance carrier denied the disputed services with the claim adjustment discussed below.

   - Procedure code A4595 billed September 14, 2018 was denied by the insurance carrier as 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." 28 TAC §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;" The status code of A4595 is "X" statutory exclusion. The insurance carrier's denial is supported, no additional payment is recommended.

   - Procedure code G0283 billed September 14, 2018 was reduced by the insurance carrier as P12 – "Workers' compensation jurisdictional fee schedule adjustment." 28 TAC §134.203 (c) states, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor.) The allowable is $14.53. 58.31/35.9996 x $14.53 = $23.53. The carrier paid $23.53. No additional payment is recommended.

   - Procedure code 97035 - "Application of a modality to 1 or more areas; ultrasound, each 15 minutes." billed September 14, 2018 was denied by the insurance carrier as 197 – "Precertification/authorization/notification absent."

     28 TAC §134.600 (p) (5) states in pertinent part, "physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning;"

     The carrier's denial is supported. Preauthorization was required but insufficient evidence was found to support preauthorization was obtained.

   - Procedure code 97140 – "Manual therapy techniques," billed September 14, 2018 was denied by the insurance carrier as 197 – "Precertification/authorization/notification absent." As shown above, preauthorization was required but insufficient evidence was found to support preauthorization was obtained. No additional payment is recommended.

   - Procedure code G0283 – "Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care" billed September 18, 2018 was reduced as 45 – "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement."

As shown above the allowable is $14.53. 58.31/35.9996 x $14.53 = $23.53. This amount is recommended.

- Procedure code 97035 "Application of a modality to 1 or more areas; ultrasound, each 15 minutes." billed September 18, 2018 was denied by the insurance carrier as 197 – Precertification/authorization/notification absent." As shown above, preauthorization was required but insufficient evidence was found to support preauthorization was obtained. No additional payment is recommended.
- Procedure code 97140 "Manual therapy techniques," billed September 18, 2018 was denied by the insurance carrier as 197 –Precertification/authorization/notification absent." As shown above, preauthorization was required but insufficient evidence was found to support preauthorization was obtained. No additional payment is recommended.
- Procedure code 99455-v4 billed September 28, 2018 was reduced with claim reduction code, P12 – "Workers' compensation jurisdictional fee schedule adjustment."

  28 TAC 134.204 (n) (14) states in pertinent part, "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (14) V4, Level of MMI for Treating Doctor--This modifier shall be added to CPT Code **99455 when the office visit level of service is equal to "moderate to high severity" level and of at least 25 minutes duration."**

  28 TAC 134.204 (3) (a) states in pertinent parts, "The following applies for billing and reimbursement of an MMI evaluation. (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier. (i) Reimbursement shall be the applicable **established patient office visit level associated with the examination.**

  The reimbursement is calculated based on the "office visit level of service equal to "moderate to high severity" and "at least 25 minutes duration" or 99214 – "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. **Usually, the presenting problem(s) are of moderate to high severity.** Typically, **25 minutes** are spent face-to-face with the patient and/or family". The allowable is $105.49. 58.31/35.9996 x $105.49 = $170.87. The carrier paid $170.87. No additional payment is recommended.

2. The total allowable of disputed services still due to the requestor is $23.53.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $23.53.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $23.53, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order

Authorized Signature

		January 30, 2019
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 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.