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
ALLISON WALLS, PHD

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-19-2392-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
DECEMBER 31, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Incorrect reduction of Designated Doctor referred testing claim."

Amount in Dispute: $299.74

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Uphold denial. Per NCCI, Code 907919column 1) has a CCI conflict with code 96116(column 2). A modifier is not allowed to override this relationship."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 29, 2018	CPT Code 90791	$0.00	$0.00
	CPT Code 96116-59 (X2)	$299.74	$0.00
	CPT Code 96101 (X13)	$0.00	$0.00
TOTAL		$299.74	$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, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the

disputed service.

3. The services in dispute were reduced/denied by the respondent with the following claim adjustment reason codes:
   - 97, 00137-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 18-Exact duplicate claim/service.
   - W3-Request for reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the value of CPT code 96116-59 included in the value of code 90791 billed on the disputed date? Is the requestor entitled to reimbursement?

Findings

The requestor is seeking reimbursement of $299.74 for CPT code 96116-59 rendered on August 29, 2018.

28 Texas Administrative Code §134.203(b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: 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."

According to the explanation of benefits, the respondent denied reimbursement for code 96116-59 based upon reason codes "97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

On the disputed date of service, the requestor billed CPT codes 90791, 96116-59, and 96101. Only code 96116-59 is in dispute.

Per CCI edits, CPT code 96116 is a component of CPT code 90791. A modifier is not allowed to differentiate the service; therefore, the respondent's denial of payment based upon reason code "97" is supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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

Signature	Medical Fee Dispute Resolution Officer	01/30/2019 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.