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
Physician Mgmt Svcs dba Injury 1 Trtmt Ctr

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-19-3352-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
March 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The insurance company has not paid the Date of service 09/07/18 stating treatment was not preauthorized and it was PreAuth."

Amount in Dispute: $132.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider did not bill a modifier that would allow 97110 and bypass NCCI. Denial for 97110 is correct."

Response Submitted by: Coventry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 7, 2018	97110	$132.44	$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 Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
3. 28 Texas Insurance Code Chapter 134.203 sets out the reimbursement guidelines for professional medical services.
4. The insurance carrier denied payment for the disputed services with the following claim adjustment codes:
   - 97 - The benefit for this service is included in the payment/allowance for another service/procedure that ahs already been adjudicated
   - MX58 – Per NCCI, the procedure code is denied, as a mutually exclusive procedure to 97150

Issues

1. Did the out-of-network healthcare provider meet the requirements of Chapter §1305.006?
2. Is the insurance carrier's denial supported?

Findings

1. The requestor billed for physical medicine services rendered on September 7, 2018 to an injured employee enrolled in the First Health TX HCN, a certified healthcare network. The requestor seeks a decision from the Division's medical fee dispute resolution (MFDR) section as an out-of-network healthcare provider.

   The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation to resolve matters involving employees enrolled in a certified health care network, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 and limited application of Texas Labor Code statutes and rules, including 28 Texas Administrative Code §133.307.

   Chapter §1305.006 outlines the insurance carrier's liability for out-of-network healthcare and states, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:

   (1) emergency care;
   (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
   (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103.

   DWC defines non-network health care in paragraph (a) (6) of the same rule as "Health care not delivered or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules …" That is, the Divisions medical fee dispute resolution section, may address disputes involving health care provided to an injured employee enrolled in an HCN, only if the out-of-network health care provider was authorized by the certified network to do so.

   Review of the submitted medical documents found "Notification of Certification" dated August 8, 2018 for "Physical Rehabilitation Therapy" under Certification No: 15202008. As the services in dispute were authorized, the applicable DWC rules will be applied during this review.

2. 28 TAC 134.203 (b) states,

   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; 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.

   Review of the NCCI edits found at www.cms.gov, finds procedure code 97110 has an unbundle relationship with procedure code 97150. The insurance 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

		June 6, 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.