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 ROCKWALL

Respondent Name
RICHARDSON HOSPITAL AUTHORITY

MFDR Tracking Number
M4-19-5278-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
August 23, 2019

Response Submitted By
No response received from insurance carrier

REQUESTOR'S POSITION SUMMARY

"Underpaid/Denied Physical Therapy Rate."

RESPONDENT'S POSITION SUMMARY

The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 26, 2019	Outpatient Physical Therapy	$127.13	$0.00

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC) in Title 28, Part 2 of the Texas Administrative Code.

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 hospital facility fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
4. The insurance carrier reduced 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 HAS ALREADY BEEN ADJUDICATED.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - W3 – REPORTING PURPOSES ONLY – Check issued
   - 231 – MUTUALLY EXCLUSIVE PROCEDURES CANNOT BE DONE ON THE SAME DAY/SETTING.

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards outpatient physical therapy services not paid under Medicare's Outpatient Prospective Payment System but under Medicare's Physician Fee Schedule. DWC *Hospital Fee Guideline,* 28 Texas Administrative Code §134.403(h) requires use of the fee guideline applicable to the code on the date of service if Medicare pays using other fee schedules. DWC *Professional Fee Guideline,* Rule 28 TAC §134.203(c) determines the maximum allowable reimbursement (MAR) using Medicare payment policies modified by DWC rules.

The insurance carrier denied disputed service code 97110 performed March 26, 2019 with claim adjustment reason codes 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated"; and 231 – "Mutually exclusive procedures cannot be done on the same day/setting."

Review of the submitted bill finds that for service date March 26, 2019, the provider performed both CPT code 97110 and code 97150 together on the same date.

Per Medicare's Correct Coding Initiative (CCI) edit payment policy, the provider may not report code 97110 on the same date as code 97150. Reimbursement for code 97110 is included in the payment for code 97150.

In certain situations, separate payment may be justified if the provider bills the code with an appropriate modifier to distinguish circumstances allowing for separate payment. Any modifier used must be supported by the medical documentation.

Review of the submitted bill finds the provider did not bill code 97110 with any modifier to distinguish circumstances that might allow for separate payment. Accordingly, the insurance carrier's denial reasons are supported. Additional payment cannot be recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of the division is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the requestor has not established that additional payment is due. As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	November 8, 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 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.