TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare Fort Worth

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-0111-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 16, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is an approved case and all claims are to be paid in full."

Amount in Dispute: $179.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…a significant separately identifiable E&M service provided requires the -25 modifier…"

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 11, 2019	99214	$179.04	$179.04

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 §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 193 – Original payment decision is being maintained
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
   - 150 – Payer deems the information submitted does not support this level of service

Issues

1. Is the insurance carrier's position statement supported?
2. What rule is applicable to fee guideline?

Findings

1. The requestor is seeking $179.04 for an evaluation and management code rendered on June 11, 2019.

   The insurance carrier states, "…a significant separately identifiable E&M service provided requires the -25 modifier…

   28 TAC §134.203 (b) (1) states, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers.

   The three codes submitted on the medical bill are;
   - 97110 - Therapeutic procedure, therapeutic exercises to develop strength and endurance 1 or more areas , each 15 minutes,
   - 97112 - Therapeutic procedure, neuromuscular reeducation of movement 1 or more areas, each 15 minutes; and
   - 99214 - Office or other outpatient visit for the evaluation and management of an established patient

   Review of the Medicare coding initiatives found insufficient evidence to support an edit exists between these three codes without appending the -25 modifier to code 99214.

   The insurance carrier's position is not supported. The service in dispute will be reviewed per applicable DWC fee guideline.

2. The applicable fee guideline is found in 28 §TAC 134.203 (c). The calculation is made using the DWC fee guideline divided by the Medicare Conversion Factor or (59.19 / 36.0391) multiplied by the Medicare Physician Fee Schedule allowable. For the disputed date of service, the calculation is; (59.19/36.0391) x $109.01 = $179.04. This amount is recommended.

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 $179.04.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
DWC hereby ORDERS the respondent to remit to the requestor $179.04, plus applicable accrued interest per 28 TAC §134.130 due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 24, 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 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

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