TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Lankford Hand Surgery Assn

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-23-1008-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
January 4, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 9, 2022	97039	$178.50	$155.00
	Total	$178.50	$155.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of the reconsideration explanation of benefits with a handwritten note, "Made proper corrections at time of reconsiderations. Please see corrections. Next step is to file a complaint of Texas Dept of Ins."

Amount in Dispute: $178.50

Respondent's Position

"Please note that the provider's initial medical bill billed a different CPT code than 97039. Initially, it was billed as 96920 which is low-level laser treatment/therapy. Following the provider's receipt of the carrier's initial EOB, the provider change the billing code from 96920 to 97039, which is an unlisted code. CV stated that the best code which describes the services is 97026 which is a class

IV, deep tissue laser. The provider should not be billing it as an UL code. …the carrier's position is that the provider is not entitled to any additional reimbursement."

Response submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the billing requirements and fee guidelines for professional medical claims.
3. 28 TAC §134.1 sets out reimbursement guidelines for workers compensation medical claims.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 119 – Benefit maximum for this time period or occurrence has been reached
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Did the requestor's medical bill meet requirements of applicable rule?
2. What rule is applicable to reimbursement?
3. Did the requestor support disputed service fair and reasonable rate?

Findings

1. The requestor is seeking reimbursement of physical therapy services rendered in August of 2022. The insurance carrier denied the claim based on submission error.

Review of the submitted medical bill found the original medical bill listed Code 96920 – Laser treatment for inflammatory skin disease (psoriasis), total area less than 250 sq cm. on the appeal, this code was marked through, and claim line indicated Code 97039 – Unlisted modality (specify type and time if constant attendance).

Review of the "Visit Note" indicates the first intervention as "Low Level Laser." Review of the parameters listed under "Low Level Laser" the health care used the correct miscellaneous code.

2. DWC Rule 134.203 (c) (1) states in pertinent part to determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. 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 annual conversion factor for disputed date of service.

Review of the Medicare Physician's fee schedule no allowable was found for Code 97039. The divisions general reimbursement rules applicable in this instance is detailed below.

The division's general reimbursement Rule at 28 TAC §134.1(e), payment for health care is calculated by applying a fee from an adopted Division rule or by applying a negotiated contract rate. In the absence of an applicable fee guideline or a negotiated contract, the payment is subject to the division's general fair and reasonable requirements described in 28 TAC 134.1 (f) found below.

DWC Rule 28 TAC 134.1(f) states in pertinent part, fair and reasonable reimbursement shall:

1. be consistent with the criteria of Labor Code §413.011;
2. ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
3. be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available

DWC requested information from both parties to support the amount billed by the requestor met the requirements of fair and reasonable reimbursement shown above. Only the requestor responded.

Review of the requestors' additional information found the following.

1. Billed amount 96920 $178.50, Gallagher Bassett paid $169.57 DOS 10/19/2022.
2. Billed amount 97039 $155.00, Gallagher Bassett paid $155.00 DOS 08/03/2022.
3. Billed amount 96920 $313.22, Gallagher Bassett paid $297.55 DOS 01/17/2023.
4. Billed amount 96920 $178.50, Sedgewick paid $178.50 DOS 01/03/2023.

Based on this review DWC finds the requestor has supported code 97039 has a fair and reasonable payment of $155.00. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services. It is ordered that Zurich American Insurance Co must remit to Lankford Hand Surgery Assn $155.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		March 31, 2023
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.