



Texas Department of Insurance, Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Work Ready Rehab, LTD. 500 Century Plaza, Dr. #165 Houston, TX 77073
Respondent Name and Box #: Box 21
MFDR Tracking #: M5-08-0099-01
Previous #: M4-04-B906-01
DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

No Position Summary was submitted by the Requestor.

Principle Documentation:

- 1. DWC 60 package
2. Total Amount Sought - \$454.90
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

No Position Summary was submitted by the Respondent.

Principle Documentation:

- 1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Table with 5 columns: Dates of Service, CPT Codes and Calculations, Denial Codes, Part V Reference, Amount Ordered. Includes rows for various dates and codes, and a Total Due row showing \$0.00.

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011 (a-d), titled Reimbursement Policies and Guidelines, and Division Rule 134.202, titled Medical Fee Guideline effective for professional medical services provided on or after August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "F72-Fee Guideline MAR Reduction (Treatment has exceeded Medicare Guidelines for length of treatment session(s)," and "O-Denial after reconsideration." Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the Requestor and Respondent. The Requestor failed to remit the fee for an IRO review. A Request to Pay was faxed on 6-18-08 giving the Requestor ten days in which to remit the fee per 133.308 (r)(7)(8) and (11). This fax was not successful. All mail sent to the Requestor's last known address has also been returned. As of 6-2-08 no fee has been received. These services have been dismissed.
2. These services were denied by the Respondent with reason code "G2-Unbundling (Included in Global) Per the National Correct Coding Policy, you can not unbundled codes when there is a code that is adequate for both procedures or included in the procedure," and "O-Denial after reconsideration."
3. Per Rule 134.202(b) this service is not included in any other service which was billed on this date of service. The Requestor billed with modifier "59 - Distinct Procedural Service." The "59" modifier is used to identify procedures/services that are not normally reported together. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury. The documentation does not clearly support that the services in dispute met the criteria to support the usage of the (-59) modifier. No reimbursement is recommended.
4. CPT97530-GO-59 is considered per Rule 134.202(b) to be a mutually exclusive procedure of CPT code 97150-GO which was billed on the same date of service. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. The Requestor billed with modifier "59 - Distinct Procedural Service." The "59" modifier is used to identify procedures/services that are not normally reported together. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury. The documentation does not clearly support that the services in dispute met the criteria to support the usage of the "59" modifier. No reimbursement is recommended.
5. CPT 97004-59 is considered per Rule 134.202(b) to be a component procedure of CPT code 97110-GO which was billed on the same date of service. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. The Requestor billed with modifier "59 - Distinct Procedural Service." The "59" modifier is used to identify procedures/services that are not normally reported together. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury. The documentation does not clearly support that the services in dispute met the criteria to support the usage of the "59" modifier. No reimbursement is recommended.
6. These services were denied by the Respondent with reason code "F1-Fee Guideline MAR Reduction. Charge exceeds the schedule maximum allowance per the Medical Fee Guideline," and "O-Denial after reconsideration." Per Rule 134.202(b) CPT Code 97018 "requires supervision." The office notes do not document supervision. No reimbursement is recommended.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code Section. 413.011(a-d), Section 413.031 and Section 413.0311  
28 Texas Administrative Code Sections 133.308 eff. 1-2-03, 134.1 eff. 5-16-02, 134.202  
Texas Government Code, Chapter 2001, Subchapter G

**PART VII: DIVISION DECISION**

\Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to **additional** reimbursement for the services involved in this dispute.

**DECISION:**

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution  
Officer

7-2-08  
\_\_\_\_\_  
Date

**PART VIII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

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