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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SAN ANTONIO SPINE & REHAB

Respondent Name
UNIVERSITY HEALTH SYSTEM

MFDR Tracking Number
M4-12-1267-01

Carrier's Austin Representative
Box Number 16

MFDR Date Received
December 27, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As stated on the attached preauthorization letter authorization was received for this CPT. On 02/07/2011 preauthorization for CPT codes 98940 and 97140 were [sic] authorized. AUTH # AP170898."

Amount in Dispute: $39.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box on June 19, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit a response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 2, 2011	97140-GP	$39.66	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 fee guideline for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 97A – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. *Per the National Correct Coding Initiative Edits.*
   - 193 – Original payment decision is being maintained. Upon review, it was determined that the claim was processed properly.

Issues

1. Did the requestor bill in conflict with the NCCI edits?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 "(b) 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."

   The requestor seeks reimbursement for CPT code 97140 rendered on March 2, 2011. The division completed NCCI edits to identify potential edit conflicts that would affect reimbursement. The following was identified:

   The requestor billed the following CPT codes on March 2, 2011 indicated on the CMS1500; 98940-GP, 97140-GP, 97110-GP and G0283-GP. Per CCI Guidelines, Procedure Code 97140 [MANUAL THERAPY TQS 1/> REGIONS EACH 15 MINUTES] has a CCI conflict with Procedure Code 98940 [CHIROPRACTIC MANIPULATIVE TX SPINAL 1-2 REGIONS]/]. Review documentation to determine if a modifier is appropriate. Review of the CMS1500's does not notate modifier -59 on the bill, as a result, reimbursement cannot be recommended for CPT code 97140-GP.
2. The division finds that the requestor is therefore not entitled to reimbursement for CPT code 97140-GP, as a result, reimbursement cannot be 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 upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 17, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **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. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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