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 and Address

TX HEALTH DBA INJURY 1 OF DALLAS
9330 LBJ FREEWAY SUITE 1000
DALLAS TX 75243

Respondent Name
Twin City Fire Insurance Co

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-12-3206-01

MFDR Date Received
June 25, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…these codes are separate procedures and not global with any other code."

Amount in Dispute: $45.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The modifier billed with this procedure is not valid for the primary service."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 6, 2012	Physical Therapy	$45.00	$45.00

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 a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care providers.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
4. 28 Texas Administrative Code §133.203 sets out the reimbursement guidelines for professional medical services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 119 – BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
   - 168 – BILLED CHARGE IS GREATER THAN MAXIMUM UNIT VALUE OR DAILY MAXIMUM ALLOWANCE FOR PHYSICAL THERAPY/PHYSICAL MEDICINE SERVICES.

Issues

1. Did the requestor submit medical claim with Division guidelines?
2. Did the respondent support reason for denial of claim?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.20(b)(1) states, in pertinent part, "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; …and other payment policies in effect on the date a service is provided…" The medical bill for the service in dispute included the -59 modifier and the GO modifier. The 59 modifier is described in AMA CPT as used to identify the procedure/services that are not normally reported together, and that are not ordinarily encountered or performed on the same day by the same provider. The GO modifier is described in AMA CPT as used to identify services delivered under an outpatient occupational therapy plan of care. Review of the medical claim finds the health care provider billed with modifiers that are allowed with the use of the disputed service. Further review finds that the disputed service 97140 is considered "Mutually exclusive procedures" of 97530. However, the requestor did receive prior authorization for both services. Therefore, the Division finds the requestor did submit the claim within applicable guidelines and use of the -59 modifier is allowed to override any payment policy edits.
2. The insurance carrier denied the disputed service as, 119 - "BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED. Review of submitted documentation finds prior authorization was obtained for disputed service, 97140, for eight units. The submitted medical record finds April 6, 2012 is listed as "8 of 8 visits". Therefore per 28 Texas Administrative Code 134.600(c) which states in pertinent part, "The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care" the Division finds the carrier's denial is not supported. This service will be reviewed per applicable rules and fee guidelines.
3. 28 Texas Administrative Code §134.203(c) is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in disputed. For services in 2012, the maximum allowable reimbursement = (TDI-DWC Conversion Factor / Medicare CONV FACT) x Non-Facility Price or; (54.86 / 34.0376) x 30.42 = $49.03.
4. The total allowable for the disputed services is $49.03. The requestor is seeking payment in the amount of $45.00. 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 $45.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $45.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March , 2014 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 Texas Administrative Code §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 the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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