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

MEDICAL EDGE HEALTHCARE GROUP
PO BOX 650268
DALLAS TX 75265-0268

Respondent Name
Texas Mutual Insurance Co

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-11-3125-01

MFDR Date Received
May 13, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Mutual Ins. Co. denied our claim, starting they paid another provider, Tech Health. On 2/14/2011, we sent a request for reconsideration, stating we were billing for the technical component, but they denied this again on 4/6/2011. When I called their phone number, their message stated that, if we disagree, to contact the Texas Department of Insurance."

Amount in Dispute: $624.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual contacted TechHealth regarding the billing from the requestor, who asserts it provided the technical portion of the imaging. Tech Health reported that (a) the requestor is in its network of imaging providers and (b) the requestor should bill TechHealth for the procedure"

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 21, 2010	72195	$624.36	$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 a medical fee dispute.
2. 28 Texas Administrative Code §134.202 sets out the medical fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 18 – DUPLICATE CLAIM/SERVICE
   - A DENIAL WAS MADE BECAUSE A DIFFERENT PROVIDER HAS BILLED FOR THE SERVICES
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

- 717 - PAYMENT HAS BEEN MADE TO TECH HEALTH FOR THE SAME SERVICES

Issues

1. Did the requestor bill in compliance with Division guidelines?
2. Did the respondent support their denial of the claim?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.202(9)(c)(I)states in pertinent part, "Commission Modifiers, HCPs billing professional medical services shall utilize the following modifiers, in addition to the modifiers prescribed by the Medicare policies required to be used in subsection (b) of this section, for correct coding, reporting, billing, and reimbursement of the procedure codes." …(I) TC, Technical Component – This modifier shall be added to the CPT code when the technical component of a procedure is billed separately." Review of the submitted bill finds no modifier was included on the claim. The requestor did not support their claim to be billing only for the technical component.
2. The carrier denied the disputed service as, 717 - "PAYMENT HAS BEEN MADE TO TECH HEALTH FOR THE SAME SERVICES." Review of carriers' response finds an Explanation of benefits dated August 17, 2010 that indicates payment was made to TECHHEALTH INC. The carrier's denial is supported.
3. Review of the submitted documentation finds that the requestor did not submit the claim to indicate billing for the technical component only via modifier and the respondent has provided evidence the disputed date of service and submitted code were paid to another provider. No additional payment can 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	February , 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.