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

BRYAN EMERGENCY PHYSICIAN
PO BOX 2283
MANSFIELD TX 76063

Respondent Name
Hartford Fire Insurance Co

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-12-1166-01

MFDR Date Received
December 7, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT 93010 is a separately payable service and should be treated as so."

Amount in Dispute: $13.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This interpretation of a study of test is an integral part of the evaluation & management service."

Response Submitted by: Hartford Fire Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 4, 2011	Professional Services	$13.90	$13.90

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 reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED.
   - 97 – PYMNT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SRVC/PX INCLUDED IN GLOBAL REIMBURSEMENT.

Issues

1. Did the respondent support their denial?

2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied the service in dispute at 97 – "PYMNT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SRVC/PX INCLUDED IN GLOBAL REIMBURSEMENT. " 28 Texas Administrative Code §134.203 (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 pay policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of National Correct Coding Initiative Edits finds there is no conflict between procedure codes 99285 and 93010. The carrier's denial is not supported. Therefore; these services will be reviewed per applicable rules and fee guidelines.
2. 28 Texas Administrative Code §134.203 is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2011, the maximum allowable reimbursement = (TDI-WC Conversion Factor / Medicare CONV FACT) x Non-Facility Price or: (54.54/ 33.9764) x $8.66 = $13.90. The total allowable for disputed services is $13.90. The carrier paid $0.00. Therefore an additional payment of $13.90 is 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 $13.90.

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 $13.90 reimbursement for the disputed services.

Authorized Signature

		January , 2014
Signature	Medical Fee Dispute Resolution Officer	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.