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

DR ANDREW BRYLOWSKI
12300 FORD ROAD STE 150
DALLAS TX 75234

Respondent Name
Safety National Casualty Corp

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-1168-01

MFDR Date Received
December 14, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since our billing department has been unable to find the code pairs submitted for billing listed under both the NCCI Edits and the Mutually Exclusive Edits as requiring modifiers when submitted together, we are requesting Dr. Brylowski be paid for the denied charges in the amount of $1528.10"

Amount in Dispute: $1.528.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made."

Response Submitted by: Flahive Ogden and Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 21, 2011	Professional Services	$1,528.10	$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 reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 236 – This procedure or procedure/modifier is not compensable with another procedure/modifier provided on the same day according to the National Correct Coding initiative.
   - 217 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Are the disputed services subject to CCI edits?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied disputed service as 236 – "This procedure or procedure/modifier is not compensable with another procedure/modifier provided on the same day according to the National Correct Coding initiative." Per 28 Texas Administrative Code §134.203 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… Review of National Correct Coding Initiative Edits Manual, Chapter 11, Section M, Central Nervous System Assessments/Tests, states in pertinent part, "(CPT codes 96101, 96188) must be distinct services..." "Central nervous system (CNS) assessment/test CPT codes (e.g., 96101-96105, 96118-96125) should not be reported for tests that are reportable as part of an evaluation and management service when performed." The division finds the carriers' denial is supported.
2. Review of the submitted documentation finds that a CCI edit does exist between 96118 and 99456 therefore, 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	January , 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.