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

CENTER FOR PAIN RELIEF
9080 HARRY HINES STE 110
DALLAS TX 75235

Respondent Name
City of Dallas

Carrier's Austin Representative Box
Box Number 53

MFDR Tracking Number
M4-12-1306-01

MFDR Date Received
December 29, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are unclear as to why they continue to deny payment for the same code billed for dates of service 7/14/11 and 7/21/11."

Amount in Dispute: $95.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on our research we find no additional recommendation is applicable and the bill in question was properly processed per TX WC Medical Fee Guideline."

Response Submitted by: JI Companies, PO Box 142649, Irving, TX 75014

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 14 – 21, 2011	Professional Services	$95.38	$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 §133.203 sets our medical bill submission requirements for health care providers.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 236 – This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was

processed properly.

Issues

1. Is the service in dispute separately payable?
2. Is the requestor entitled to reimbursement?

Findings

1. The service in dispute was denied, in part as 236 – "This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative." Per 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 payment policies, including its coding; billing; correct coding initiatives (CCI) edits…" Medicare's CCI edits indicate whether a service billed is considered a component procedure of another service provided on the same day. The requestor billed 77003. Review of the CCI public files, along with the medical bill provided by the parties finds that Procedure 77003 is a component code of another service (64520) billed on the same day. Separate payment for the services billed may be justified if a modifier is used and supported by medical documentation.

2. Review of the submitted documentation finds no documentation to differentiate between the services provided. Separate payment is not 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

		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.