



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Arlington Orthopedic Association

**Respondent Name**

New Hampshire Insurance Co

**MFDR Tracking Number**

M4-12-3240-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

June 28, 2012

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "S2112 has been made a valid code."

**Amount in Dispute:** \$3,000.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** Written acknowledgement of medical fee dispute received July 6, 2012 however, no written response submitted.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 20, 2012	S2112	\$3,000.00	\$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 medical fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 16 – Claim/service lacks information which is needed for adjudication
  - 18 – Duplicate claim/service
  - 561 – According to the state fee schedule this procedure code is not considered a valid reimbursable code

**Issues**

1. Did the requestor support disputed service was billed in compliance with Division guidelines?
2. Is the requestor entitled to reimbursement?

**Findings**

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier’s Austin representative box, which was acknowledged received on July 6, 2012. The insurance carrier did not submit a response for consideration in this review. Per the Division’s former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, “If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information.” Accordingly, this decision is based on the available information.
2. 28 Texas Labor Code §134.203(b) states in pertinent part, “(b) 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; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided...” The carrier denied the disputed service as, 561 – “According to the state fee schedule this procedure code is not considered a valid reimbursable code.” Review of CPT code finds; Procedure code S2112, service date February 20, 2012, has a status indicator of I, which denotes codes that are not valid for Medicare purposes. Medicare uses another code for the reporting and payment of these services. Therefore, the carrier’s denial is supported.
3. The disputed service was not coded based on Medicare coding guidelines. 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	August , 2014 Date
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**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.**