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
William D Strinden MD

Respondent Name
TPS Joint Self Ins Funds

MFDR Tracking Number
M4-13-0560-01

Carrier's Austin Representative
Box Number 11

MFDR Date Received
October 26, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is appropriate to bill CPT code 69990 when the operating microscope was used to repair the artery."

Amount in Dispute: $417.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The carrier acknowledged receipt of Notice of Medical Fee Dispute however, no written position was submitted.

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
February 9, 2012	69990	$417.42	$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 health care providers
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 16 – Claim/service lacks information which is needed for adjudication.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did the requestor support disputed service are separately payable?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier denied the disputed service as, 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." 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; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the document titled "Corrected claim" finds that the requestor did not submit a modifier with the disputed service as stated in requestor's correspondence dated May 7, 2012. The Division concludes that the requestor did not meet the requirements of 28 Texas Administrative Code §134.203(b)(1) therefore the Carrier's denial is supported.

2. The requestor billed 69990. The requestor states, "That is why I used the -59 modifier," however the claim did not show the 59 modifier; consequently code 69990 cannot be considered a separate service. Therefore in accordance with 28 Texas Administrative Code §134.203(b)(1) no additional reimbursement 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	May 21, 2014 Date

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.