



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

Carl Cannon

Respondent Name

Indemnity Insurance Co of North

MFDR Tracking Number

M4-13-0982-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

December 14, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Your explanation of denial is that you did not receive all information needed for adjudication. This denial is inappropriate."

Amount in Dispute: \$5,760.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Acknowledgement of medical fee dispute received December 21, 2012. However no written position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 6, 2012	29882, 29881, 29874	\$5,760.00	\$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 §133.308 sets out procedures for requesting review by an Independent Review Organization (IRO).
3. 28 Texas Administrative Code §134.402 sets out reimbursement guidelines for ambulatory surgical centers.
4. Texas Labor Code §408.021 sets out provisions regarding entitlement to medical benefits.
5. Texas Labor Code §413.031 sets out provisions regarding medical dispute resolution.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 16 – Not all info needed for adjudication was supplied
 - 97 – Charge included in another charge or service
 - PI – Payor Adj – Not necessary / reasonable chg
 - 193 – Original payment decision maintained
 - 54 – Multiple Physicians/Assistants not covered.

Issues

- 1. Is there an unresolved issue of medical necessity regarding disputed services?
- 2. Did requestor support medical claim submission are in compliance with Division guidelines?
- 3. 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 as received on December 21, 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. The insurance carrier denied disputed services billed under procedure code 29881, 29882, 29874 with reason codes PI – “Payor Adj – Not necessary / reasonable chg.” 28 Texas Administrative Code §133.305(b) requires that “If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021.” 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for services for which there is a medical fee dispute. No documentation was submitted to support that the issues of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution of the services billed under procedure code 80101; therefore, these services will not be considered in this review.
- 3. The insurance carrier denied the disputed services as, 15 – “Not all info needed for adjudication was supplied.” Review of the submitted documentation finds;
 - a. Preauthorization dated 7-2-12 for procedure codes 29880, 29877, and G0289
 The carrier’s denial is supported. Also, the procedure codes submitted on the medical claim are subject to Correct Coding Initiatives and Assist at Surgery not being allowed. 28 Texas Administrative Code §134.402(6) states in pertinent part, "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare. The Division finds the submitted claims did not comply with division guidelines as Medicare policy does not allow assist at surgery for procedures billed and CCI edits prevents procedures being billed together without documentation to support “separate and distinct” procedures performed.
- 4. For the reasons stated above, 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

July 23, 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.