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

CENTENNIAL MEDICAL CENTER
6514 MCNEIL DR BLDG 2 STE 201
AUSTIN TX 78729

Respondent Name
Travelers Insurance

Carrier's Austin Representative Box
Box Number 05

MFDR Tracking Number
M4-14-1071-01

MFDR Date Received
December 11, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Hospital appealed the denial twice, and maintained in each appeal that S0020 is indeed a valid code for marcaine with epinephrine."

Amount in Dispute: $4,158.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As the bill was not properly completed, it was returned to the Provider as incomplete pursuant to Rule 133.200."

Response Submitted by: Travelers Insurance.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 16, 2013	Outpatient Hospital Services	$4,158.28	$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 §133.200, sets out procedures for insurance carriers upon receipt of medical bills.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Other: S0020 is not a valid procedure code.

Issues

1. Were the codes submitted valid on date of service provided?
2. What is the applicable rule for determining reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §133.200 states in pertinent part, " (a) Upon receipt of medical bills submitted in accordance with §133.10(a)(1) and (2) of this chapter (relating to Required Medical Forms/Formats), an insurance carrier shall evaluate each medical bill for completeness… …(1) Insurance carriers shall not return medical bills that are complete, unless the bill is a duplicate bill. (2) Within 30 days after the day it receives a medical bill that is not complete as defined in §133.2 of this chapter, an insurance carrier shall:
   (A) complete the bill by adding missing information already known to the insurance carrier, except for the following:
      (i) dates of service;
      (ii) procedure/modifier codes;
      (iii) number of units; and
      (iv) charges; or
   (B) return the bill to the sender, in accordance with subsection (c) of this section. …1. (c) The proper return of an incomplete medical bill in accordance with this section fulfills the insurance carrier's obligations with regard to the incomplete bill."

   Review of submitted documentation finds the carrier's rejection of the claim is supported.

2. Procedure code S0020 is not a valid code or was not in effect on the date the services were provided. 28 Texas Administrative Code §134.403(d) requires that, for coding, billing, reporting, and reimbursement of covered health care, system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions as specified in the rule. Medicare payment policies require the accurate reporting of medical services using valid Healthcare Common Procedure Coding System (HCPCS) codes. Review of the submitted documentation finds that the procedure code reported is not recognized by Medicare as a valid HCPCS code for the date the services were rendered. This service does not meet the requirements of §134.403(d). Reimbursement cannot 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

		January 29, 2014
Signature	Medical Fee Dispute Resolution Officer	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.