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
ETMC First Physicians

Respondent Name
Service Lloyds Insurance Co

MFDR Tracking Number
M4-14-1710-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
February 10, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above patient claim has been denied by Service Lloyds/Corvel also appeals have denied stating procedure code 99221-57 denied as included in the surgery per Medicare guidelines this service is allowed and the modifier separates this service from the surgery…"

Amount in Dispute: $198.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As this was a minor procedure (26011), no separate reimbursement is allowed."

Response Submitted by: White Espey, PLLC P.O. Box 152949, Austin, TX 78715

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 31, 2013	99221	$198.00	$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 the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – Charge included in another charge or service
   - 193 – Original payment decision maintained

Issues

1. Did the requestor support services are separately payable?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, 97 – "Charge included in another charge or service." 28 Texas Administrative Code §134.203(b) 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; 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 with any additions or exceptions in the rules." Review of the submitted medical bill finds the following. Per CCI edits, procedure code 99221 and 26011 has a conflict. These procedures are not allowed on the same date unless a modifier is used and documentation support separate and distinct procedures were performed. No documentation was found to support a separate and distinct procedure was performed.
2. Requirements of Rule 134.203(b) are not met. 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

		September , 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.