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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TIMOTHY MARKS, MD

Respondent Name
WAL MART ASSOCIATES INC

MFDR Tracking Number
M4-15-2245-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
MARCH 23, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Rational For Payment: This is not the case for this DOS, as this patient did not have an encounter on this date. Therefore, the denial has no merit. Furthermore, there was no payment in association with another service. Review of medical records necessary for patient evaluation and management of there medical care. This was a separate and distint medical service. I have enclosed a copy of the DOP so that you can see exactly what the services actually was."

Amount in Dispute: $110.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The self-insured employer has not changed its position with respect to the original denials and the denials of the requestor's request for reconsideration. Please see the attached EOBs regarding this matter."

Response Submitted by: Hoffman Kelley, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 23, 2014	CPT Code 99358 Prolonged Evaluation and Management Service	$110.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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, effective March 1, 2008, sets out the reimbursement guidelines for professional services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.
   - 243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
   - 5081-Reduction or denial of payment resulting after a reconsideration was completed.

Issues

Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean 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."

CPT code 99358 is defined as "Prolonged evaluation and management service before and/or after direct patient care; first hour."

The requestor wrote "The previous day I spoke to the peer review doctor regarding precertification."

The Division finds that a phone call seeking preauthorization for treatment does not meet the definition of CPT code 99358. As a result, reimbursement is not 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

		05/28/2015
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, 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 MFDR 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.