TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Muilenburg, Ralph T

Respondent Name
Metropolitan Transit Authority

MFDR Tracking Number
M4-15-4132-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
August 24, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In this case, 99358 was used to document the non face to face time where Dr. Muilenburg reviewed Dr. Warnocks report which is enclosed."

Amount in Dispute: $190.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on September 2, 2015. The insurance carrier did not submit a response for consideration in this review. Per 28 Texas Administrative Code §133.307(d)(1), "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.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 6, 2015 January 26, 2015	99358	$190.00	$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 sets out the reimbursement guidelines for professional medical services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P14 – The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day
   - W3 – Additional reimbursement made on reconsideration
   - 193 – Original payment decision is being maintained.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code P14 – "The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day." 28 Texas Administrative Code §134.203 (b) requires that

   > 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…

   Review of the submitted information finds that the submitted code in dispute is 99358 – "Prolonged evaluation and management service before and/or after direct patient care; first hour." Review of the Status code associated with this code is "B" Bundled-code. Review of the 2015 CMS Physician Fee Schedule finds no fee associated with the service in dispute. Therefore, the Division finds the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

2. Per requirements of Rule 134.203 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

		November , 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.