



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

Fort Duncan Medical Center

Respondent Name

TPS Joint Self INS Funds

MFDR Tracking Number

M4-16-0500-01

Carrier's Austin Representative

Box Number 53

MFDR Date Received

October 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Fort Duncan Medical Center to audit their Workers Compensation claims. We have found in this audit you have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule that started 3/01 2008..."

Amount in Dispute: \$169.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The carrier acknowledged the receipt of Medical Fee Dispute on November 3, 2015. 28 Texas Administrative Code 133.307 (d)(1) states, "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. 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." No response was submitted this review will be based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 17, 2015	96372x2	\$169.20	\$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 §134.403 sets out the acute care hospital fee guideline for outpatient services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 236 – This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the NCCI edits or work comp state regs/fee schedule requirements
 - 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 (96372) with claim adjustment reason code 236 – “This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the NCCI edits or work comp state res/fee schedule requirements.” 28 Texas Administrative Code §134.403(d) states, “For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...”

Review of the CCI Guidelines, Procedure Code 96372 has a CCI conflict with Procedure Code 99284. Review of the submitted documentation does not support this service was “separately identifiable” from the primary procedure. The insurance carrier’s denial reason is supported. Additional reimbursement cannot be recommended.

2. Pursuant to Rule 134.403(d) no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has 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

December , 2015
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 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.