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
Texas Bone and Joint Center

Respondent Name
Preferred Professional Insurance Company

MFDR Tracking Number
M4-16-2916-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
May 23, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… the above claim was denied due to an error."

Amount in Dispute: $3441.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier has no record of having previously received those particular charges for a DOS of 06/02/1015 [sic] before receiving these bills with a 'send date' of 03/01/2016…"

Response Submitted by: Parker and Associates, L.L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 2, 2015	Drug Screen	$3441.03	$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 fee guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - Notes: "NO ADDIIOTNAL [sic] DUE. PLEASE RESUBMIT WITH VALID CODES"

Issues

1. What are the services in dispute?
2. Did the insurance carrier appropriately raise timely filing?
3. Is the insurance carrier's reason for denial of payment supported?

Findings

1. Review of the Medical Fee Dispute Resolution Request (DWC060) finds that, while the requestor listed procedure codes 83992 and G0434-QW, the requestor is seeking $0.00 for these codes. Therefore, they will not be considered for this dispute. The disputed procedure codes that are considered for this dispute are: 80346, 80361, 80364, 80336, 80368, 80370, 80373, 80372, 80367, 80324, 80365, 80356, 80348, 80354, 80366, 80332, 80349, 80358, 80359, 80360, 80353, 80355, and 80345.

2. In their position statement, the insurance carrier asserted, "The carrier has no record of having previously received those particular charges for a DOS of 06/02/1015 [sic] before receiving these bills with a 'send date' of 03/01/2016…" 28 Texas Administrative Code §133.307(d)(2)(F) states, in relevant part,

   > The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review…

   Review of the submitted documentation does not support that denial for timely filing was presented to the requestor prior to the date the request for MFDR was filed. Therefore, this issue will not be considered for this dispute.

3. The insurance carrier denied disputed services stating, "NO ADDIIOTNAL [sic] DUE. PLEASE RESUBMIT WITH VALID CODES." 28 Texas Administrative Code §134.203(b) states,

   > 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 information finds that the procedure codes in question have a status I, which indicates that the codes are "Not valid for Medicare purposes – Medicare uses another code for reporting of, and payment for these services." The insurance carrier's denial reason is supported. Additional 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 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	August 29, 2016
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.