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
GILBERT MAYORGA, MD

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-18-3571-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MAY 24, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…the patient was seen for a designated doctor evaluation. Total fees as allowed by the Texas Fee Guideline were in the amount of $1750.00. However, to date we have not received payment from the carrier."

Amount in Dispute: $1,750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Fee Schedule team has completed their review …and determined that the bill priced correctly based on the submitted documentation, invalid diagnosis code on billing."

Response Submitted By: Gallagher Bassett Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15, 2017	CPT Code 99456-W5-WP Designated Doctor Evaluation	$1,250.00	$0.00
	CPT Code 99456-W8-RE Return to Work Evaluation	$500.00	$0.00
TOTAL		$1,750.00	$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, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code § 133.10, effective April 1, 2014 sets out the healthcare providers billing procedures.
3. 28 Texas Administrative Code §133.20, effective May 2, 2006, sets out the procedure for submitting medical bills by health care providers.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18-Duplicate claim/service.
   - 146-Diagnosis was invalid for the date(s) of service reported.

Issues

Is the respondent's denial of payment for codes 99456-W5-WP and 99456-W8-RE supported?

Findings

The requestor is seeking dispute resolution for CPT code 99456-W5-WP in the amount of $1,250.00, and $500.00 for code 99456-W8-RE for a total of $1,750.00. A review of the submitted explanation of benefits finds that the respondent denied payment based upon "146-Diagnosis was invalid for the date(s) of service reported."

To determine if the respondent's denial of payment is supported, the division refers to the following statute:

- 28 Texas Administrative Code § 133.10(f)(1)(Q) and (R) states, "All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care:
  - (Q) procedure/modifier code (CMS-1500, field 24D) is required; and
  - (R) diagnosis pointer (CMS-1500, field 24E) is required."

- 28 Texas Administrative Code §133.20(c) requires "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills."

Based upon the above referenced statute and submitted documentation, the division finds:

- The requestor listed the diagnoses in box 21 of the CMS-1500: [redacted].
- ICD-10 diagnosis code "[redacted]" is not valid.
- The requestor is not due reimbursement because of the billing errors for the diagnosis.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due.

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	9/26/2018 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.