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
Ellis County Medical County Assoc

Respondent Name
Zhat Insurance Co

MFDR Tracking Number
M4-19-4698-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 27, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our claim should not continue to deny for Medical Necessity, when all notes and results have been submitted, and my explaining the need for A4467 being medically necessary."

Amount in Dispute: $65.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the review and findings stated above, no additional payment is due to the provider for the disputed HCPCS code A4467 as this procedure was correctly disallowed pursuant to the 28 Texas Administrative Code §134.203(b)(1) Medical Fee Guideline for Professional Services."

Response Submitted by: The Zenith

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 13, 2018	A4467	$65.00	$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:
   - 629 – The medically unlikely edits (MUE) from CMS has been applied to this procedure code
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Issues

1. Is the insurance company's denial supported?

Findings

1. The requestor is seeking $65 for Code A4467 – Belt, strap, sleeve, garment, or covering, any type. The insurance carrier denied the service as not being separately payable.

   28 TAC §134.203 (b) states in pertinent part,

   > (b) 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;

   The code in dispute has a Medicare Status Code of N – Non-covered services.

   Based on the above, the insurance carrier's denial is supported. No additional payment is 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Peggy Miller	July , 2019
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 Rule §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. **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.