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
ORTHOTEXAS PHYSICIANS AND SURGEONS

Respondent Name
NORGUARD INSURANCE CO

MFDR Tracking Number
M4-20-0780-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
NOVEMBER 25, 2019

REQUESTOR'S POSITION SUMMARY

"On this date of service, claim denied stating 'bundled'. Written request from the carrier for causation is payable per Rule 134.120(f)(5)(A)(g). See the attached documentation that supports the services provided. Please reprocess claim for payment immediately."

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

No response was submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 27, 2019	CPT Code 99080	$100.00	$100.00

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.120, effective May 2, 2006, sets out the reimbursement guideline for medical documentation.
3. The services in dispute were reduced/denied by the respondent with the following claim adjustment reason codes:
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. No allowance was recommended as this procedure has a Medicare status of "B" bundled.
   - 284-No allowance was recommended as this procedure has a Medicare status of "B" (Bundled).

Issues

Is the requestor entitled to reimbursement for CPT code 99080 rendered on June 27, 2019?

Findings

1. The requestor is seeking medical dispute resolution in the amount of $81.00 for copies of medical records (CPT code 99080) that were sent to the Designated Doctor on August 23, 2019.
2. The Austin carrier representative for Norguard Insurance Co is Stone Loughlin & Swanson, LP. Stone Loughlin & Swanson, LP acknowledged receipt of the copy of this medical fee dispute on December 3, 2019. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information
   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).
3. The respondent denied reimbursement for code 99080 based upon, "97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. No allowance was recommended as this procedure has a Medicare status of "B" bundled."
4. To determine if reimbursement is due the DWC refers to the following statutes:
   - 28 TAC § 134.120(f) states, "The reimbursements for medical documentation are: (5) narrative reports: (A) one to two pages--$100
   - Per 28 TAC §134.203(a)(7), "Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program. Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies."
5. The DWC finds:
   - On June 25, 2019, the respondent requested a medical opinion regarding the claimant's current symptoms as they relate to the compensable injury of [redacted] and to a pre-existing condition.
   - The requestor billed for a 1 page narrative.
   - The respondent denied reimbursement based upon Medicare policy regarding code being a status "B" code.
   - Per 28 TAC §134.203(a)(7), the provisions in DWC rules take precedence over any conflicting provisions in Medicare; therefore, the respondent's denial of payment is not supported.
   - Per 28 TAC § 134.120(f)(5), the requestor is due reimbursement of $100.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $100.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $100.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	01/17/2020 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.