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
UT Southwestern MSP

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-21-0699-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 22, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $78.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its position of the denial for cpt code 71045, per NCCI edits it is included in other comprehensive procedure for this date of service."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 24, 2019	71045	$78.00	$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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 236 – This billing code is not compatible with another billing code provided on the same day according to NCCI or workers compensation state regulations/fee schedule requirements
   - 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor is seeking reimbursement of professional medical services rendered December 24, 2019. The insurance carrier denied the disputed service based on NCCI edits. Review of the submitted documentation found only one service billed. The medical records related to only one service performed on the disputed date of service. The insurance carrier's denial for NCCI edit between services is not supported and will not be considered during this review.

28 TAC §133.307 (c) (2) sets out the form and manner required when requesting a medical fee dispute.

> (J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter.
>
> (N) a position statement of the disputed issue that includes the requestor's reasoning for why the disputed fees should be paid, how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and how the submitted documentation supports the requestor's position for each disputed fee issue.

The documentation sent with the request for medical fee dispute from the requestor did not contain any appeal documentation nor was a position statement that met the requirements of the rule shown above submitted. No payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment 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

		January 20 , 2021
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.