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**
ALSACE URGENT CARE

**Respondent Name**
TASB RISK MANAGEMENT FUND

**MFDR Tracking Number**
M4-21-1431-01

**Carrier's Austin Representative**
Box Number 47

**MFDR Date Received**
APRIL 12, 2021

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "This is the initial workers comp visit so the charges should be paid. All the other 2 dates of service have been paid accordingly."

**Amount in Dispute:** $317.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Service code 99204 denied per NCCI…component to procedure code 96372…Service code 36416 is denied as the status indicator of this code indicates that it is not paid."

**Response Submitted By:** TASB Risk Fund

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 7, 2021 | CPT Code 99204 | $300.00 | $0.00 |
| | CPT Code 36416 | $17.00 | $0.00 |
| TOTAL | | $317.00 | $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 (DWC).

**Background**

1. 28 Texas Administrative Code (TAC) §133.307, effective February 22, 2021, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. Neither party to the dispute submitted any explanation of benefits for the disputed services.

**Issues**

Is the requestor entitled to reimbursement for CPT codes 99204 and 36416 rendered on January 7, 2021?

**Findings**

1. The requestor is seeking medical fee dispute resolution in the amount of $317.00 for CPT codes 99204 and 36416 rendered on January 7, 2021.
2. Because neither party to the dispute submitted any explanation of benefits for the disputed services, the disputed services will be reviewed per the fee guideline.
3. The fee guidelines for disputed services is found at 28 TAC §134.203.
4. 28 TAC §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."
5. "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
6. On the disputed date of service the requestor billed CPT codes: 99204, 73562-RT, 73110-RT, 73610-RT, 73630-RT, 96372, 85025, 36416, 99080-73, and J1865. Only codes 99204 and 36416 are in dispute.
7. Per CCI edits, code 99204 is a component of code 96372; however, a modifier is allowed to differentiate the service. A review of the submitted billing finds the requestor did not attach a modifier to code 99204 to differentiate the service; therefore, the respondent's denial of payment is supported.
8. Per CMS fee schedule, code 36416 is a status "B" code. A status "B" code indicates that it is bundled into payment of another service; therefore, the respondent's denial of payment is supported.

**Conclusion**

For the reasons stated above, the DWC finds that the requestor has not established that 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 DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | 5/13/2021 |
| 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 28 TAC §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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**.