TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Jasso Gabriel PHD

Respondent Name
Starr Indemnity & Liability Co

MFDR Tracking Number
M4-24-0141-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 15, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 21, 2023	90791	$0.00	$0.00
February 21, 2023	99354	$710.64	$0.00
February 21, 2023	96130	$0.00	$0.00
February 21, 2023	96131	$0.00	$0.00
February 21, 2023	96136	$0.00	$0.00
February 21, 2023	96137	$0.00	$0.00
	Total	$710.64	$0.00

Requestor's Position

"The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134. The carrier has not responded or has denied this claim in its entirety following our filing of Request for Reconsideration. Therefore, we are filing for Medical Dispute Resolution at this time per Rule 133.307."

Amount in Dispute: $710.64

Respondent's Position

The respondent did not submit a position statement. Rather they submitted copies of "Medical Dispute Response" dated September 20, 2023. This document was faxed on September 28, 2023

and October 13, 2023 and did not contain a carrier's position statement.

Response submitted by: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets out the billing and coding guidelines for professional medical services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 181 – Procedure code was invalid on the date of service.
- 4783 – The procedure code billed by the provider has been deleted from the CPT and is no longer considered a valid CPT code.

Issues

1. Is the insurance carrier's denial supported?

Findings

1. The requestor is seeking reimbursement of Code 99354. All other codes listed on the submitted DWC60 have $0.00 in dispute. The insurance carrier denied this code as being invalid on the date of service.

   DWC Rule 134.230 (b) (1) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including is coding…".

   Review of the applicable AMC coding guideline found 99354 was deleted on January 1, 2023 prior to the disputed date of service, February 21, 2023. The insurance carrier's denial is supported. No payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been

discussed, it was considered.

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October 18, 2023
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.