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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARTIN S GLORE MD PA
2719 W TRINTON RD
EDIBURG TX 78539

Respondent Name
ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-09-6041-01

MFDR Date Received
FEBRUARY 6, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached codes are payable through the Medicare guidelines with the correct modifiers that we have used in order for them not to bundle with any other codes. I do not agree with their denial and would like for you to review."

Amount in Dispute: $325.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Date of service 9-2-08 was reduced per the AMA guidelines by Coventry (Audit)."

Response Submitted by: ESIS

Respondent's Supplemental Position Summary dated December 7, 2010: "The AWCA Operations Team reviewed the bill for [Claimant] and confirms the bill was re-priced in accordance with the provider's contracted rate. In response to the Texas Department of Insurance's inquiry regarding compliance with 28 Tex. Admin. Code 133.4, Martin Glore has been made aware of his participation status with AWCA since April 1, 2004."

Response Submitted by: Aetna

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 4, 2008	CPT Code 36000-59	$46.90	$0.00
	CPT Code 90774-59	$103.20	$0.00
	CPT Code 90775-59	$138.18	$0.00
	CPT Code 90772-59	$37.50	$0.00
TOTAL		$325.78	$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.

Background

1. Former 28 Texas Administrative Code §133.305, effective January 15, 2007, sets forth general provisions regarding dispute of medical bills.
2. Former 28 Texas Administrative Code §133.307, effective January 15, 2007, sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.

   The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 45-Charges exceed fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - W1-Workers Compensation state fee schedule adjustment.
   - 150-Payer deems the information submitted does not support this level of service.
   - 900-068-Additional reconsideration of this bill and submitted documentation does not support additional payment.
   - 850-107-Initial allowance recommended in accordance with the state fee schedule guidelines.
   - W2-Workers compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment.
   - 850-334-Documentation does not meet the CPT requirements for modifier 59. The procedure is included in another procedure.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307 for disputed date of service?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307 for disputed date of service?

Findings

1. According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e) (3) (H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved as of the undersigned date.
2. The requestor has failed to support that the disputed services rendered on March 7 and 8, 2007 are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

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 upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		03/20/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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