**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**

EDWARDS T BRADLEY
7401 S MAIN STREET
HOUSTON TX 77030-4509

**Respondent Name**
Texas Mutual Insurance Co

**Carrier's Austin Representative Box**
Box Number 54

**MFDR Tracking Number**
M4-12-1022-01

**MFDR Date Received**
December 2, 2011

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "CPT code 23472 billed w/mod 22. Usually allows additional rem."

**Amount in Dispute:** $765.41

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Because the requestor has not provided information to justify additional reimbursement through the -22 modifier, no further payment is due."

**Response Submitted by:** Texas Mutual Insurance Co

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| August 5, 2011 | Professional Services | $765.41 | $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. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-B5 – COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED.
   - CAC-59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES
   - 329 – ALLOWANCE FOR THIS SERVICE REPRESENTS 50% BECAUSE OF MULTIPLE OR BILATERAL RULES
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES

**Issues**

1. Did the respondent support the insurance carrier's reason for the reduction of service in dispute?
2. Is the requestor entitled to reimbursement?

**Findings**

1. The carrier denied the claim as CAC-B5 – "COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED". Per 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "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; … and other payment policies in effect on the date a service is provided…" The medical bill for the service in dispute included -22 modifier. Medicare Claims Processing Manual, Chapter 12, Section 20.4.6 states, "The fees for services represent the average work effort and practice expenses required to provide a service. For any given procedure code, there could typically be a range of work effort or practice expense required to provide the service. Thus, carriers may increase or decrease the payment for a service only under very unusual circumstances based upon review of medical records and other documentation." Review of the documentation titled "Operative Report" describes details of Procedure Code 23472, "Arthroplasty, glenohumeral joint, total shoulder (glenoid and proximal humeral replacement (e.g. Total shoulder." However, no documentation was found to support the specifics of increased time, work effort and practice expense beyond the allowed amount. Therefore, the carrier's reduction is supported.
2. Review of the submitted documentation finds no evidence to support that the disputed service had a greater work effort and/or practice expense than the allowed amount. No additional payment can be recommended.

**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**

| Signature | Medical Fee Dispute Resolution Officer | February , 2014<br>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**.