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
BARRETT BROWN

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-12-1563-01

Carrier's Austin Representative Box
Box Number 54

MFDR Date Received
January 11, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It appears that the carrier is utilizing the 5 digit zip code directory instead of the 9 digit file. The 4 digit extension is required in order to delineate the boundaries from Harris County (locality 18) and other (locality 99)."

Amount in Dispute: $6.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary:"The requestor's concern is that the 5 digit zip code puts the requestor's location into locality 99 instead of 18, i.e. HoustonHarris County. However, there is a link on the same database shown immediately to the left, that is, "Mailing Industry Information." It opens up into a separate pop-up window, (Attachment 2). It clearly indicates the carrier route is in Harris County. For these reasons no additional payment is due the requestor.

Response Submitted by: Texas Mutual Insurance Company.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 15, 2011	99213 and 73560	$6.43	$0

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 the reimbursement guidelines for E/M services

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

- W1 – workers compensation state fee schedule. Subject to multiple procedure discounts and is paid at 100 percent of the fee schedule amount per the Texas physicians fee schedule, Medicare guidelines.

- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

Issues

1. Did the carrier pay correct reimbursement according to Centers for Medicare and Medicaid Services (CMS) locality fee schedule?
2. Is the requestor entitled to additional reimbursement?

Findings

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…" §134.203(a)(5) states that "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, values and 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." The "Zip Code to Carrier Locality File" located on the CMS website states that zip code 77494-1341 resides in Harris county/Houston. Review of the submitted documentation finds that the carrier did not use correct participation amount.

2. For the reasons stated above, the services in dispute are not eligible for additional payment pursuant to 28 TAC §134.203 (c).

   The requestor received reimbursement in the amount of $154.71; the amount eligible for payment is $154.71. Therefore, no additional payment is 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.

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Authorized Signature

		June , 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.