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

TX HEALTH DBA INJURY 1 OF DALLAS
9330 LBJ FREEWAY SUITE 1000
DALLAS TX 75243

Respondent Name
Hartford Casualty Insurance Co

Carrier's Austin Representative
Box Number 47

MFDR Tracking Number
M4-13-2116-01

MFDR Date Received
April 22, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In summary, it is our position that Hartford insurance has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered to …. Your help in resolving this case…"

Amount in Dispute: $250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As of January 1, 2013 revised CPT coding options went into effect… CPT code 90801 is no longer considered a valid reimbursement code."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 2, 2013	Professional Services	$250.00	$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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.20 sets out requirements for medical bill submission by health care providers.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION
   - 561 – ACCORDING TO THE STATE FEE SCHEDULE THIS PROCEDURE CODE IS NOT CONSIDERED

A VALID REIMBURSABLE CODE. PLEASE RE-SUBMIT A VALID CODE.

- 247 – A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE.

Issues

1. Did the requestor submit disputed service in compliance with Division guidelines?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as, 56,"ACCORDING TO THE STATE FEE SCHEDULE THIS PROCEDURE CODE IS NOT CONSIDERED A VALID REIMBURSABLE CODE. PLEASE RE-SUBMIT A VALID CODE". 28 Texas Administrative Code §134.20(c) states, in pertinent part, "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills. Review of submitted medical billing finds code 90801 which was not in effect on date of service January 2, 2013. Therefore, the carriers' denial is supported.
2. The services in dispute are subject to 28 Texas Code that requires coding submitted on medical bills reflect the current codes found in Current Procedural Terminology (CPT). The disputed service was billed with a code that expired on 12/31/2012. No additional reimbursement 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	March 3, 2014 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 Texas Administrative Code §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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 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 §141.1(d).

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