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

TEXAS HEALTH OF DENTON
3255 W PIONEER PARKWAY
ARLINGTON TX 76013

Respondent Name
Netherlands Insurance Co

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-14-1137-01

MFDR Date Received
December 19, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Their EOB states this HCPC is not payable which must have been done in error, per the NCCI edits for a FACILITY it is payable. We submitted an appeal to the carrier but they have denied our request for the additional allowance still due. Please process this claim for the correct allowable per ASC RULE 134:402: Outpatient Hospital Rule 134.03, HCPS's are payable at 200% of the correct fee schedule allowable."

Amount in Dispute: $76.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however, no response received.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 16, 2013	96374	$76.16	$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 the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Per CCI, the procedure code is denied, based on standard of medical, surgical practice. Procedure included in 99284.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the service in dispute as 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated". 28 Texas Administrative Code §134.203 states, in pertinent part, "for coding, billing, reporting, and reimbursement of professional medical services, Texas Worker's 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…" Per the Centers for Medicare and Medicaid Services, National Correct Coding Initiative Policy Manual, Chapter 11, Section (B)(3), "Because the placement of peripheral vascular access devices is integral to intravenous infusions and injections, the CPT codes for placement of these devices are not separately reportable. Thus, insertion of an intravenous catheter (e.g., CPT cods 36000, 36410) for intravenous infusion, injection or chemotherapy administration (e.g., CPT codes 96360-96368, 96374-76379, 96409-96417) should not be reported separately. The Division finds the Carrier's denial is supported.
2. Based on the provisions of 28 Texas Administrative Code §134.203 no additional payment can be recommended as the services in dispute are listed as "Do not report with codes for which IV push or infusion is an integral part of the procedure."

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

		March 5, 2014
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 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.