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

THR FORT WORTH
3255 W PIONEER PKWY
ARLINGTON TX 76013

Carrier's Austin Representative Box
Box Number 47

Respondent Name

Hartford Fire Insurance Co

MFDR Date Received
January 3, 2014

MFDR Tracking Number
M4-14-1250-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please submit 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: There is no documentation to support an IV push medication was given on 8/4/13. CPT 96374 should still be denied as NOT DOCUMENTED.

Response required from: Gallagher Bassett, 6504 International Pkwy # 2100 – Plano, TX 75093

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
August 4, 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. Former 28 Texas Administrative Code, §133.307, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §133.210 sets out the requirements of supporting medical documentation.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.

Issues

1. Are the services in dispute separately payable?
2. Are the services in dispute supported by medical documentation?

3. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier denied the services 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 §134.20(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 AMA CPT Code 96374. Per Medicare policy, procedure code 96374 may not be reported with procedure code 99284 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended. The carrier's denial via the Explanation of Benefits is supported.

2. In the carriers' response they state, "There is no documentation to support an IV push medication was given on 8/4/13. 28 Texas Administrative Code §134.210 states in pertinent part, "When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form…" Review of the submitted documentation finds no mention of disputed service in medical record. Therefore, the Division finds the carriers' response is also supported.

3. Review of the submitted documentation finds the services in dispute are subject to CCI edits and are not separately payable. Also, nothing found in submitted documentation to support services as billed. Therefore no additional reimbursement can be recommended.

Conclusion

For the reason stated above, the Division finds that the requestor has not established that additional reimbursement is due.

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 reimbursement is not recommended.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 25, 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.