



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

Lake Pointe Medical Center

Respondent Name

Netherlands Insurance Co

MFDR Tracking Number

M4-15-0550-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

October 8, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...Outpatient Hospital Rule 134.03, HCPS's are payable at 200% of the correct fee schedule allowable."

Amount in Dispute: \$74.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however no position statement submitted.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 13, 2013	Outpatient Hospital Services	\$74.68	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
- 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.
 - 193 – Original payment decision is being maintained.

Issues

- What is the applicable rule for determining reimbursement for the disputed services?
- Is the requestor entitled to reimbursement?

Findings

- The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin

representative box, which was acknowledged, received on October 15, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

2. The carrier denied the disputed service 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 §134.403 (d) states in pertinent part, “For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...”. Review of the National Correct Coding Initiative Manual, Chapter XI (B), Therapeutic or Diagnostic Infusions/Injections and Immunizations, Evaluation and Management Services , “CPT Codes 90000 - 99999 Under OPPS, hospitals may report drug administration services (CPT codes 96360-96376) and chemotherapy administration services (CPT codes 96401-96425) with facility based evaluation and management codes (e.g., 99212-99215) if the evaluation and management service is significant and separately identifiable.” Review of the submitted documentation did not identify a separately identifiable service. The carrier’s denial is supported.
3. The total recommended payment for the services in dispute is \$0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has 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

December , 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.