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
Texas Health Plano

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-15-1010-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 1, 2014

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: $112.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual paid code 73080 and denied payment of code 73070 because the NCCI Edits for hospitals shows code 73070 can be paid separately from 73080 when a modifier is applied. Review of the bill does not reflect use of one by the requestor. No payment is due."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 6, 2014	73070	$112.34	$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 §134.403 sets out the reimbursement guidelines for Hospital Facility Fee Guidelines.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 236 – This billing code is not compatible with another billing code provided on the same day according to NCCI or workers compensation state regulations/fee schedule requirements.
   - 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.
   - 193 – Original payment decision is being maintained.

Issues

1. Did the requestor support service is dispute is separately payable?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as, 236 – "This billing code is not compatible with another billing code provided on the same day according to NCCI or workers compensation state regulations/fee schedule requirements." 28 Texas Labor Code §134.403(3) states in pertinent part, "Medicare payment policy" means reimbursement methodologies, models, and values or 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. (d) 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 with any additions or exceptions specified in this section…" Review of National Correct Coding Initiative edits, http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html, "procedure code 73070 has a CCI conflict with procedure code 73080. Documentation to support use of applicable modifier may be used." Review of the medical claim finds no modifier was used. The carrier's denial is supported.
2. Provisions of Rule 134.403 not met. No additional payment 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	February 23, 2015 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.