



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Texas Health Fort Worth

Respondent Name

Texas Mutual

MFDR Tracking Number

M4-15-1366-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

January 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Texas Health Fort Worth to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule that started 3/01/2008..."

Amount in Dispute: \$348.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor seeks reimbursement of codes 96361, 96374, and 96375. Code 99361 is an add-on code for 96360, which was not billed. Code 96374, absent a modifier, is bundled to code 99285 according to the NCCI Edits. Code 96375 is the add-on code for code 96374, which is bundled to 99285. By extension code 96375 is not separately payable when code 96374 is bundled."

Response submitted by: Texas Mutual

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 16, 2014	Outpatient Hospital Services	\$348.66	\$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:
 - 446 – This add-on code has been denied as the principal procedure was not billed
 - 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. What is the applicable rule for determining reimbursement for the disputed services?

2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative 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." And (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..." CMS Medicare Learning Network, (MLN) Matters®Number: SE1320 states in pertinent part, "An add-on code is a HCPCS/CPT code that describes a service that is always performed in conjunction with the primary service. An add-on code is eligible for payment only if it is reported with the appropriate primary procedure performed by the same practitioner." Reimbursement for the disputed services is calculated as follows:
 - Per Medicare policy, procedure code 96361 is an add-on code. Primary code not paid. Separate payment is not recommended.
 - Per Medicare policy, procedure code 96374 may not be reported with the procedure code 99285 without supporting documentation that details how the procedure is separate and distinct to the primary procedure performed. When documentation exists the appropriate use of a modifier will allow separate payment. However no documentation or modifier was found. Separate payment is not recommended.
 - Per Medicare policy, procedure code 96375 is an add-on code. Primary code not paid. Separate payment is not recommended.
2. The total allowable reimbursement for the services in dispute is \$0.00. No additional reimbursement can be recommended.

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

		March 12, 2015
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.