TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health of Fort Worth

Respondent Name
Fort Worth ISD

MFDR Tracking Number
M4-15-3086-01

Carrier's Austin Representative
Box Number 16

MFDR Date Received
May 21, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note per the NCCI Edits this line is not bundled and we show should have processed for payment."

Amount in Dispute: $206.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation no additional payment is being made at this time. Upon review it was determined that the submitted bill was paid correctly per the fee schedule and guidelines. Per the NCCI edits the disputed code is considered bundled."

Response Submitted by: Injury Management Organization, 10235 West Little York Road, Suite 265, Houston, TX 77040

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 28, 2014	96360	$206.06	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 outpatient facility services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 411 – National Correct Coding Initiative edit – either mutually exclusive of or integral to another service performed on the same day

- 193 – Original payment decision is being maintained

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 411 – "National Correct Coding Initiative edit – either mutually exclusive or integral to another service performed on the same day." 28 Texas Administrative Code §134.403 (d) requires that "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 National Correct Coding Initiative Manual, Chapter XI, Evaluation and Management Services, CPT Codes 90000 – 99999, B. Therapeutic or Diagnostic Infusions/Injections and Immunizations, "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. In these situations modifier 25 should be appended to the evaluation and management code." Review of the submitted medical record finds;

    a. Page 7 of Texas Health Fort Worth record for claimant states, "Normal Saline, 1,000ml Start 08/28/2014 1600 - End 08/28/2014 1600."

    The insurance carrier's denial reason is supported as the submitted documentation indicates the starting and ending time as the same. This does not support the service in dispute as significant and separately identifiable. Reimbursement cannot be recommended.

2. The Division finds submitted documentation does not meet requirements of Rule 134.403. 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	June 29, 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, 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 MFDR 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.