



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Texas Health of Plano

Respondent Name

Hartford Accident & Indemnity Co

MFDR Tracking Number

M4-16-1693-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

February 18, 2016

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: \$342.09

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation found the following: CPT 96375 denied as inclusive and CPT 93005 denied as per NCCI, code has been disallowed. Additional reimbursement is not recommended."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 10, 2015	96375x3, 93005	\$342.09	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.

- 906 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient code editor), Component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed.
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.
- 1014 – The attached billing has been re-evaluated at the request of the provider.

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 97 – “Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated” and 243 – “The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.” 28 Texas Administrative Code §134.403 (d) states,

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 CMS, National Correct Coding Initiative Policy Manual for Medicare Services, Chapter XI Medicine Evaluation and Management Services CPT codes 90000 – 99999 for national correct coding initiative policy manual for Medicare services find;

*CPT code (e.g., 99281-99285) should not be reported by a physician with a drug administration CPT code unless **the drug administration service is performed at a separate patient encounter in a non-facility setting on the same date of service.** In such situations, the evaluation and management code should be reported with modifier 25.*

Review of the submitted medical claim finds code 99285 -25 was submitted, however insufficient evidence was found to support that the drug administration was performed at a separate patient encounter in a non-facility setting. The insurance carrier’s denial reason is supported. Additional reimbursement cannot be recommended.

Procedure code 93005 has a status indicator of Q1, which denotes STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date. Review of the submitted claim finds procedures with a “V” status, specifically procedure 99285 which has a status indicator of “V.”

2. The Division finds based on the requirements of Rule 134.403 (d) 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

March 15, 2016
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.