



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 AZLE

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-18-4744-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

August 6, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/denied APC."

Amount in Dispute: \$865.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Review of the NCCI Edits reveals that absent a modifier code 74175 is comprehended by code 74174 and 96374 also comprehended by 74174."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 8, 2018	Outpatient Facility Services: 74175, 96374	\$865.59	\$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 hospital facility fee guideline for outpatient services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment 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.
 - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
 - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
 - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
 - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards outpatient facility services subject to DWC’s *Hospital Facility Fee Guideline*, Rule §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors published in the Federal Register, as modified by DWC rules.

Rule §134.403(d) requires that for coding, billing, reporting, and reimbursement of covered health care, 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 the rule.

Per Medicare payment policy regarding Correct Coding Initiative (CCI) edits:

- Procedure code 74175 may not be reported with code 74174 billed on the same date—a modifier may be allowed to distinguish separate services for consideration of additional payment. The health care provider did not bill this service with a modifier; therefore, payment for this service is included in the reimbursement for procedure code 74174. Additional payment is not recommended.
- Procedure code 96374 may not be reported with either code 74175 or 74174 billed on the same date—in both cases a modifier may be allowed to distinguish separate services for consideration of additional payment. The health care provider did not bill this service with a modifier; therefore, payment for this service is included in the reimbursement for procedure code 74174. Additional payment is not recommended

No other services from this bill are in dispute. Accordingly, no additional payment is 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

September 13, 2018
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307.

A party seeking review must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWCO45M) in accordance with the form’s instructions. The division must receive the request within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 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.