



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 Plano

Respondent Name

Bitco National Insurance Co

MFDR Tracking Number

M4-19-1327-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 5, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT 96361 was denied incorrectly by the payer for reason code 107 "denied-qualifying service not paid or identified". This code has a status indicator S and is payable under OPPS as a separate APC payment."

Amount in Dispute: \$72.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...there was no qualifying service that was paid or identified. Before an additional service is billed, the qualifying service must be billed. ...the provider is not entitled to reimbursement for CPT code 96361."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 28, 2018	96361	\$72.93	\$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 guidelines of outpatient hospital services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 107 – Denied – qualifying svc not paid or identified

Issues

- 1. Are the insurance carrier’s reasons for denial of payment supported?

Findings

- 1. The requestor is seeking reimbursement of code 96361 – “Intravenous infusion, hydration; each additional hour.” The insurance carrier denied disputed services with claim adjustment reason code 107 – “Qualifying svc not paid or identified.” 28 Texas Administrative Code §134.403 (d) states in pertinent part,

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 CCI edits found an edit exists between code 96361 – “Intravenous infusion, **hydration**; each additional hour” and code 96374 – “Therapeutic, prophylactic, or **diagnostic injection** (specify substance or drug); intravenous push, single or initial substance/drug.” The carrier’s denial is supported 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

Medical Fee Dispute Resolution Officer

November 30, 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, 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 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. **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.