



# 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 Dallas

**Respondent Name**

Hartford Underwriters Insurance Co

**MFDR Tracking Number**

M4-19-2240-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

December 17, 2018

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "...We are appealing the incorrect bundling of CPT codes 96374 and 96361, both billed with a modifier 59 with a status indicator of S meaning separate APC payment is to be reimbursed."

**Amount in Dispute:** \$522.26

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Services were processed in accordance with Texas Guidelines, Rule 134.403."

**Response Submitted by:** The Hartford

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 19, 2018	Outpatient Hospital Services	\$522.26	\$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:
  - 86 – Service performed was distinct or independent from other services performed on the same day
  - Q97 – The benefit for this service is included in the payment/allowance for another service /procedure that has already been adjudicated
  - QS301 – This service is included in primary or more extensive procedure

## Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

## Findings

1. The requestor is seeking reimbursement for Code 96374 - "Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug" and 96361 - "Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)", billed August 19, 2018 during an outpatient hospital encounter.

The insurance carrier denied disputed services with claim adjustment reason QS301 - "This service is included in primary or more extensive procedure." The respondent stated at the time of reconsideration, "...both billed with a modifier 59 with a status indicator of S meaning separate APC payment is to be reimbursed."

28 TAC §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 Medicare payment policy regarding use of the "59" modifier found at [www.cms.gov](http://www.cms.gov) states,

***Distinct Procedural Service:*** Under certain circumstances, it may be necessary to indicate that a procedure or service was **distinct or independent from other non-E/M services performed on the same day**. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual

*Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used.*

Review of the ED Provider Notes "Medication details" page 17 indicates the following;

- Lidocaine-epinephrine (PF) 1%-1:200,000 solution
- Ondansetron (Zofran) solution
- Sodium chloride (NS flush) syringe
- Normal Saline 1,000ml

Based on this review insufficient evidence was found in the medical record to support the services in dispute are separate and distinct from the emergency room services. Based on the Medicare payment policy shown above, the NCCI edit that exists between Code 12002 and the codes 96374/96361 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

\_\_\_\_\_  
January 16, 2019  
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.**