



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 Kaufman

Respondent Name

Travelers Indemnity Co

MFDR Tracking Number

M4-19-3360-01

Carrier's Austin Representative

Box Number 5

MFDR Date Received

September 18, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPTs 96374 & 96375 should not bundle per CCI edits stating that a modifier is required for separate reimbursement. Modifiers 59 & 25 are present on bill..."

Amount in Dispute: \$527.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the documentation and determined the Provider was properly reimbursed."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: August 2, 2018, 96374, 96375, 99284, \$527.02, \$4.76

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 billing and fee guidelines for outpatient hospital services.
3. 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
- P12 - Workers' compensation jurisdictional fee schedule adjustment

## Issues

1. Is the insurance carrier's reason for denial or reduction of payment supported?
2. Is the requestor due an additional payment?

## 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 96375 - "Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)", billed August 2, 2018 during an outpatient hospital encounter.

The insurance carrier denied disputed services with claim adjustment reason 97 - "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." The respondent stated at the time of reconsideration, "CPTs 96374 & 96375 should not bundle per CCI edits stating that a modifier is required for separate reimbursement. Modifiers 59 & 25 are present on bill...."

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 Provide Notes" page 8 indicate the following;

- Sodium chloride (NS flush) syringe (discontinued)
- Sodium chloride 0.9% (Normal Saline)

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 Codes 64450 and the codes 96374/97675 is supported. No additional payment is recommended.

2. Procedure code 99284 has status indicator V as the criteria subject to comprehensive packaging was not met. This code is assigned APC 5024. The OPSS Addendum A rate is \$355.53, multiplied by 60% for an unadjusted labor amount of \$213.32, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of \$208.11. The non-labor portion is 40% of the APC rate, or \$142.21. The sum of the labor and non-labor portions is \$350.32. The Medicare facility specific amount of \$350.32 is multiplied by 200% for a MAR of \$700.64.

The total recommended reimbursement for the disputed services is \$700.64. The insurance carrier paid \$695.54. The requestor is seeking \$4.76. This amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$4.76

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$4.76, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

**Authorized Signature**

		March 27, 2019
Signature	Medical Fee Dispute Resolution Officer	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.**