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
MIDLAND MEMORIAL HOSPITAL

Respondent Name
ZURICH AMERICAN INSURANCE COMPANY OF IL

MFDR Tracking Number
M4-19-4423-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 7, 2019

Response Submitted By
Flahive, Odgen & Latson, Attorneys at Law, PC

REQUESTOR'S POSITION SUMMARY

"we have verified that per the NCCI Edits this code does not bundle to neither code previously paid and should be paid at the 200% of the allowable."

RESPONDENT'S POSITION SUMMARY

"Per CMS PTP, out-patient NCCI edit table, the CPT code 64450 bundles into CPT code 96365…"

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
December 19, 2018	Outpatient Hospital Services: 64450	$1,027.94	$0.00

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 hospital facility fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 236 – THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NCCI OR WORKERS COMPENSATION STATE REGULATIONS /FEE SCHEDULE REQUIREMENTS.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

Is the requestor entitled to additional reimbursement?

Findings

The insurance carrier denied CPT code 64450 with claim adjustment reason code 236 – "THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NCCI OR WORKERS COMPENSATION STATE REGULATIONS /FEE SCHEDULE REQUIREMENTS."

Rule §134.403(d) requires that "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" with any additions or exceptions specified in the division's rules.

Medicare payment policy regarding correct coding initiative (CCI) edits requires that procedure code 64450 may not be reported with code 96365 on the same date—a modifier may be used to distinguish separate services to allow additional payment if appropriate and supported by the medical documentation.

The provider did bill code 96365 for services rendered the same date as code 64450. The health care provider did not report code 64450 with a modifier to distinguish the services as separate. Reimbursement for code 64450 is already included in the payment for code 96365. Accordingly, the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

The total recommended division fee guideline reimbursement for all billed services is $769.64.
The insurance carrier paid $775.98. No additional payment is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the division finds the requestor has not established that additional payment is due. As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	July 3, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). 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 field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute 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.