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
Seton Med Center Harker Heights

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-4503-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 17, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $367.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "According to NCCI edits cpt code 96374 is part of comprehensive code 71275, therefore 96374 requires appropriate modifier for reimbursement. The provider submitted an appeal but did not bill a modifier. Audit staff maintained denial for cpt code 96374… No payment is due."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 6, 2019	96374	$367.42	$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

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 reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- 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
- 193 – Original payment decision is being maintained

Issues

1. Is the insurance carrier's reason for denial of payment supported?

Findings

1. The requestor is seeking $367.42 for outpatient hospital services provided on February 6, 2019. The insurance carrier denied disputed services with based on the NCCI edits. 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 with any additions or exceptions specified in this section

Review of the NCCI edits found an edits exists between the code in dispute 96374 and code 99285 both billed February 6, 2019. The insurance 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

		July 12, 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.