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
M4-20-0030-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
September 6, 2019

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $666.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The date of service in dispute was processed in accordance with Texas Workers' Compensation Guidelines, 28 TAC §134.403."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 24, 2019	96375, 96374, 96361	$666.29	$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:
   - 150 – Payer deems the information submitted does not support this level of service
   - 45 – Charges exceeds fee schedule/maximum allowable or contracted legislated fee arrangement
   - 107 – Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 292 – This procedure code is only reimbursed when billed with the appropriated initial base code
- 906 – In accordance with clinical based coding edits, component code of comprehensive medicine, evaluation and management services procedure (9000-99999) has been disallowed

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 additional reimbursement in the amount of $666.29 for code 96375, 96374, 96361 rendered on May 24, 2019. The insurance carrier denied the disputed services based on Medicare payment policies.

   28 TAC §134.403 (d) requires system participants to apply Medicare payment policies in effect on the date of services are provided.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, National Correct Coding edits and Add-on code edits.

   Review of these payment policies found the following results:

   - Code 96375. Was denied upon reconsideration as having a CCI edit with code 72158. Review of the submitted medical bill found no modifier included nor did the documentation support a separate procedure. The insurance carrier's denial is supported.
   - Code 96374. Was denied upon reconsideration as having a CCI edit with code 72158 and 99285. Review of the submitted medical bill found no modifier included nor did the documentation support a separate procedure. The insurance carrier's denial is supported.
   - Code 96361. Was denied upon reconsideration as the related or qualifying claim/service was not previously paid. Review of the submitted Add-on Code edits found code 96361 is an add-on code to 96374 which was not paid based on the CCI edit with codes 72158 and 99285. The insurance carrier's denial is supported.

Conclusion

For the reasons stated above, DWC 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

		September 26, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.