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 Rockwall

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
N4-20-1373-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 3, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DOS Not Paid."

Amount in Dispute: $442.74

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the carrier's position is that that procedure was not compatible with another procedure on the same date for which the provider was already being reimbursed."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 2, 2019	97364, 97365	$442.74	$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:
   - 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).

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor is seeking additional reimbursement of services provided during an emergency room visit on July 2, 2019. The codes listed on the DWC060 is 97364 and 97365 however, the codes on the submitted bill were 96374 and 96375. The codes are the ones reviewed below. The insurance carrier denied the disputed services as non-compatible with another procedure.

28 TAC 134.403 (d) states in pertinent part, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided for coding, billing, reporting, and reimbursement of health care covered in this section."

Review of the NCCI edits found at www.cms.gov, found the following, "The administration of drugs and fluids other than antineoplastic agents, such as growth factors, antiemetics, saline, or diuretics, may be reported with CPT codes 96360-96379. If the sole purpose of fluid administration (e.g., saline, D5W, etc.) is to maintain patency of an access device, the infusion is neither diagnostic nor therapeutic and **shall not be reported separately**."

Based on the above, the insurance carrier's denial is supported. No additional payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC 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 requestor has not established payment 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	March 6, 2020 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.