Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PALLADIUM FOR SURGERY DALLAS

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-09-B422-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 24, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Billed timely and pmt is due"

Amount in Dispute: $685.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has re-audited the bill and will be sending out a check for $616.64 plus interest in the next day or two."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 10, 2008	Procedure code 64483	$685.54	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §134.402 sets out the fee guidelines for ambulatory surgical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 1GL – CORRECT CODING INITIATIVE BUNDLE GUIDELINES INDICAT THIS CODE IS A COMPREHENSIVE COMPONENT OF ANOTHER CODE ON THE SAME DAY (609) ANSI - 97
   - 1TW – "BASED ON FURTHER REVIEW, NO ADDITIONAL ALLOWANCE IS WARRANTED." (90) ANSI - W4
   - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.
   - W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.

Issues

1. Are the insurance carrier's denial reasons supported?

Findings

1. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.402(d), effective August 31, 2008, 33 *Texas Register* 6830, which requires that "For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section." The insurance carrier denied disputed procedure code 64483 with reason codes 1GL – "CORRECT CODING INITIATIVE BUNDLE GUIDELINES INDICAT THIS CODE IS A COMPREHENSIVE COMPONENT OF ANOTHER CODE ON THE SAME DAY (609) ANSI - 97"; AND 97 – "PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE." Review of Medicare's national correct coding initiative edits finds that procedure code 64483 may not be reported with procedure code 63056 when performed on the same date of service—a modifier is not allowed to distinguish separate service. Accordingly, the Division finds that the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	June 27, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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