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 Alliance

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-15-3747-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 14, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…the date of service is after 3/01/08 thus the claim should be paid according to §134.403(f)(1)(A&B) of the newly revised Texas Fee Schedule. Based on your payment of $1,634.96, a supplement payment is still due of $348.66."

Amount in Dispute: $348.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor expects payment of code 96374. According to the NCCI Edits code 9374 is not separately billable from code 99285 without an appropriate modifier. There is no modifier with 96374 on the bill. Code 96375 was also billed. Code 96375 is an add on code to be used with 96374. However, since code 96374 is not payable, the add on code is also not payable."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 13, 2014	96361, 96374, 96375	$348.66	$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 facility services provided in an acute care hospital.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B15 – This service/procedure requires that a qualifying service/procedure be received and covered the qualifying other service/procedure has not been received/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
   - 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure
   - 446 – This add-on code has been denied as the principal procedure was not billed

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes 446 – "This add-on code has been denied as the principal procedure was not billed" and B-15 - "This service/procedure requires that a qualifying service/procedure be received and covered the qualifying other service/procedure has not been received/adjudicated."

   28 Texas Administrative Code §134.403 (d) 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." Review of the services provided finds:

   - CPT Code 96361 – Add-on code is eligible for payment if one of the listed primary procedure codes is also eligible for payment to the same practitioner for the same patient on the same date of service. The CPT description is "Intravenous infusion, hydration; each additional hour." Review of page 13 of the "ED Physician Note" finds: Normal Saline 1,000mL, Starts/Ends 08/13/14 1630 – 08/13/14 1633." The submitted record shows an infusion of three minutes which does not support the code as submitted.
   - CPT Code 96375 – Add-on code - if one of the listed primary procedure codes is also eligible for payment to the same practitioner for the same patient on the same date of service. As the primary procedure (96374) was not eligible for payment, no separate reimbursement can be recommended.
   - CPT Code 96374 was denied as 435 – "Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure." The CMS, 2014 NCCI Policy Manual, Chapter 11, "Under OPPS, hospitals may report drug administration services (CPT codes 96360-96376) and chemotherapy administration services (CPT codes 96401-96425) with facility based evaluation and management codes (e.g., 99212-99215) if the evaluation and management service is significant and separately identifiable. In these situations modifier 25 should be appended to the evaluation and management code."

     While the 25 modifier was added to code 99285 (evaluation and management code), review of the submitted documentation found no information to support the disputed service was significant and separately identifiable or "the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the **usual** preoperative and postoperative care associated with the procedure that was performed."

   The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

2. Per 28 Texas Administrative Code §134.403 (f) "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register." The OPPS reimbursement factors for separate reimbursement of the services in dispute were not met. No separate reimbursement can be 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 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 disputed services.

Authorized Signature

		July , 2015
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 28 Texas Administrative Code §133.307, 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 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 §141.1(d).

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