



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

UMC Physician Network

**Respondent Name**

ZNAT Insurance Co

**MFDR Tracking Number**

M4-24-2604-01

**Carrier's Austin Representative**

Box Number 47

**DWC Date Received**

July 29, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 12, 2024	96372	\$49.00	\$28.18
<b>Total</b>		\$49.00	\$28.18

### Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration dated June 11, 2024 that states, "The CPT: 96372 is required when administrating injection code J1885 during the office visit. Medicare allows the code for reimbursement."

**Amount in Dispute:** \$49.00

### Respondent's Position

"The disputed code 96372 was denied as inclusive to 99203-25. When an injection is given during an office visit service provided by a physician, the cost of administering the injection is included in the payment for the office visit. Therefore, no additional payment is due to the provider."

**Response submitted by:** TheZenith

### Findings and Decision

## Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

## Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.203](#) sets out the reimbursement guidelines for professional medical services.

## Denial Reasons

- 217 – TX The value of this procedure is included in the value of another procedure performed on this date.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

## Issues

1. Is the insurance carrier's denial supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to reimbursement?

## Findings

3. The requestor is seeking reimbursement of 96372 – "Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular." The insurance carrier denied the claim line stating the service is packaged/bundled into another procedure.

DWC Rule 28 Texas Administrative Code §134.203(a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare." 28 Texas Administrative Code 134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other.

Review of the applicable Medicare NCCI Procedure to Procedure (PTP) Edits at [www.cms.gov](http://www.cms.gov), for the disputed date of service found that code 96372 is allowed with code 99203 and is not packaged. The insurance carrier's denial is not supported.

2. DWC Rule 28 Texas Administrative Code §134.203(c)(1) states, "...To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification...For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$53.68..."

The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

$(\text{DWC Conversion Factor} \div \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$  or  $67.81/32.7442 \times \$13.61(\text{CMS allowable for locality Lubbock - Rest of Texas}) = \$28.18.$

3. The total allowable DWC fee guideline reimbursement is \$28.18. This amount is recommended.

### Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has established that reimbursement is due.

### **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Znat Insurance Co must remit to UMC Physician Network \$28.18 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
September 5, 2024

Date

### **Your Right to Appeal**

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at [www.tdi.texas.gov/forms/form20numeric.html](http://www.tdi.texas.gov/forms/form20numeric.html). DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field

office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).