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
Texas Health of Plano

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-15-1748-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Texas Health of Plano to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule that started 3/01/2008…"

Amount in Dispute: $357.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however no position statement submitted.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 17, 2014	72265	$357.95	$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 §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 904 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient code editor), Component code of comprehensive radiology services procedure (700`00-79999) has been disallowed.
   - 193 – Original payment decision is being maintained

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on February 18, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
2. The carrier denied the disputed service as, 904 – "In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient code editor), Component code of comprehensive radiology services procedure (7000-79999) has been disallowed." 28 Texas Administrative Code §134.403 (d)states in pertinent part, "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 with any additions or exceptions specified in this section,…" Review of the CCI edits finds a conflict does exist. While a modifier with supporting documentation can over ride this relationship. The medical claim did not contain a modifier or supporting documentation found to support a separate and distinct service. The Carrier's denial is supported.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 72265 has a status indicator of Q2, which denotes T-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicator T that are billed for the same date of service. This code may be separately payable only if no other such procedures are billed for the same date. Review of the submitted information finds that OPPS criteria for separate payment have not been met. Payment for this service is included in the payment for procedure code 72132 billed on the same claim. The no modifier was used. Separate payment is not recommended.
4. The total recommended payment for the services in dispute is $0.00. No additional amount is 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

Signature	Medical Fee Dispute Resolution Officer	April 9, 2015 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, 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 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 MDR 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.