



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

Frisco Medical Center

Respondent Name

Hartford Fire Insurance Co

MFDR Tracking Number

M4-15-3988-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

August 10, 2015

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: \$1,689.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider is disputing non-payment of CPT code 20680. The reimbursement for this code was withheld as the charge for this procedure is included and/or bundled within the value of another procedure performed. This bill was processed correctly per Outpatient Prospective Payment System (OPPS)."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: August 14 - 21, 2014, Outpatient Hospital Services, \$1,689.54, \$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:
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
 - 193 – Original payment decision is being maintained
 - W3 – Additional payment made on appeal/reconsideration
 - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. What is the applicable rule pertaining to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 243 – “The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.” 28 Texas Administrative Code §134.403 (d) requires that “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.”

Per the CMS web site, www.cms.hhs.gov, Medicare Claim Processing Manual, Chapter 4 – Part B Hospital, Section 10.4.1, “T- packaged services are services for which separate payment is made only if there is no service with status indicator T reported with the same date of service on the same claim. When there is a claim that includes a service that is assigned status indicator T reported on the same date of service as the T-packaged service, the payment for the T-packaged service is packaged into the payment for the service(s) with status indicator T and no separate payment is made for the T-packaged services. T-packaged services are assigned status indicator Q2.”

The submitted medical claim contained the CPT codes, 29891 –RT, 27680 –RT, and 20680 all of which are assigned a status indicator of “T”. Per the following link on the CMS web site, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html>, Addendum B, July 2014, the disputed service (20680) is shown as Q2 or T-packaged. The insurance carrier’s denial reason is supported.

2. Per the above referenced Medicare payment policy, no additional 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

Signature _____ Medical Fee Dispute Resolution Officer _____ September 2, 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, 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.