



# 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 of Fort Worth

**Respondent Name**

Amerisure Insurance Co

**MFDR Tracking Number**

M4-16-0109-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

September 14, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Please note per the NCCI edits this line is not bundled and we show should have processed for payment."

**Amount in Dispute:** \$111.60

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Guidelines indicate that any code billed with Status Indicator Q1 becomes a packaged APC if billed on the same date of service as a HCPCS/CPT codes assigned Status Indicator S, T, V, or X. Based on the guideline, CPT 73130 becomes a packaged service due to CPT codes 12005, 96372, 99283 and 90471."

**Response Submitted by:** MCMC

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 26, 2015	73130	\$111.60	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient facility services provided in an acute care hospital.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 97 – The benefit for this is included in the pymt/allowance for another service/procedure that has already been adjudicated

- W3 – Additional payment made on appeal/reconsideration

### **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 code 97 – “The benefit for this is included in the pymt/allowance for another service/procedure that has already been adjudicated.” 28 Texas Administrative Code §134.403(d) states, “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 submitted information finds that this dispute is related to services performed in an Outpatient Acute Care Hospital. The Medicare policy found at, [www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html) finds the code in dispute (73130) on Addendum B with a Status Indicator of Q1. This Q1 Status Indicator is assigned to STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date. Review of the entire submitted bill finds Procedure code 12005 has a status indicator of T, Procedure code 96372 has a status indicator of S, and Procedure code 99283 has a status indicator of V.

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

2. The Division finds per Rule 134.403 the applicable Medicare Payment Policy (OPPS) classifies the service in dispute as packaged and therefore not separately payable.

### **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

\_\_\_\_\_  
October , 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.**