



# 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 Stephenville

**Respondent Name**

New Hampshire Insurance Co

**MFDR Tracking Number**

M4-16-0356-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

October 8, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "HRA has been hired by Texas Health of Stephenville to audit their Workers Compensation claims. We have found in this audit you 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:** \$206.06

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** 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 October 15, 2015. The insurance carrier did not submit a response for consideration in this review. 28 Texas Administrative Code §133.307(d)(1) states, "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." Accordingly, this decision is based on the available information.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 1 – 3, 2014	Outpatient Hospital Services	\$206.06	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 16 – Claim/service lacks information or has submission/billing effort(s) which is needed for adjudication

- 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 adjus
- 193 – Original payment decision is being maintained

**Issues**

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. The service in dispute was denied as 97 – “The benefit for this service is included in the payment/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 with any additions or exceptions specified in this section,

Per Medicare policy, procedure code 96374 may not be reported with procedure code 99284 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.

2. The total allowable reimbursement for the services in dispute is \$0.00. 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	November 30, 2015 Date
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## ***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 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.**