



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 Dallas

Respondent Name

Liberty Mutual Fire Insurance

MFDR Tracking Number

M4-16-1270-01

Carrier's Austin Representative

Box Number 1

MFDR Date Received

January 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please submit this claim for the correct allowable per ASC Rule 134:402: Outpatient Hospital Rule 134.03, HCPS's are payable at 200% of the correct fee schedule allowable. Please note per the NCCI Edits this line is not bundled and show should have processed for payment."

Amount in Dispute: \$162.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The charge for date of service January 13, 2015 was denied as packaged into the APC rate for the payable code G0382."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 26, 2015	Outpatient Hospital Services	\$162.92	\$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:
 - MSIN – This is a packaged item. Services or procedures included in the APC rate, but not paid separately.
 - 193 – Original payment decision is being maintained. It was determined that this claim was processed properly.

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 for date of service April 26, 2015 with claim adjustment reason code MSIN – This is a packaged item. Services or procedures included in the APC rate, but not paid separately.” 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 with any additions or exceptions specified in this section,.”

Review of the Medicare Claims Processing Manual, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPOS), 10.4, C, 2, at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf>

*STV-packaged services are services for which separate payment is made **only** if there is no service with status indicator S, T, V or reported with the same date of service on the same claim. If a claim includes a service that is assigned status indicator S, T, V reported on the same date of service as the STV- packaged service, the payment for the STV-packaged service is packaged into the payment for the service(s) with status indicator S, T, V and no separate payment is made for the STV-packaged service. STV-packaged services are assigned status indicator Q1. See the OPPOS Webpage at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> for identification of STV-packaged codes.*

Review of the submitted claim finds;

- Procedure code 12001 has a status indicator of Q1, which denotes 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.
2. Pursuant to the above mentioned Medicare payment policy, the insurance carrier’s denial reason is supported as code 12001 is 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	January 28, 2016 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, 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.