



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 Spine Joint

Respondent Name

American Insurance Co

MFDR Tracking Number

M4-17-0177-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 23, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Explanation of Review states the procedures are packaged and not paid separately. However, our position is that this should not prevent the Hospital from receiving reimbursement on the entire bill."

Amount in Dispute: \$764.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of an acknowledgement of receipt of the medical fee dispute resolution on October 3, 2016. Texas Administrative Code §133.307 (d) (1) states, "Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (1) Timeliness. 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." As no response was received this dispute will be reviewed based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 23, 2015	Outpatient hospital services	\$764.00	\$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 services provided in an

outpatient setting.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 1 – This is a package item. Services or procedures included in the APC rate, but not paid separately
 - 2 – Recommendation of payment has been based on this procedure code, 80053, which best describes services rendered
 - 3 – Recommendation of payment has been based on this procedure code, 05027, which best describes services rendered
 - 4 – Recommendation of payment has been based on this procedure code, 36415, which best describes services rendered
 - 97 – The benefit for this services is included in the payment/allowance for another service/procedure that has already been adjudicated
 - W3 – Request for reconsideration
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

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

Findings

1. The requester seeks additional reimbursement in the amount of \$764.00 for outpatient hospital services rendered on September 23, 2015.

The insurance carrier reduced the disputed services with following notes, 1 – “This is a packaged item. Services or procedures included in the APC rate, but not paid separately.” This denial was maintained at the time of reconsideration.

Review of the submitted medical claim finds the “type of bill” in box 4 of the CMS-1450 is 131 or “Hospital Outpatient.” Outpatient hospital services are subject to the requirements of 28 Texas Administrative Code 134.403 (d) which 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...

The applicable Medicare payment policy is located at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

The resources that define the components used to calculate the Medicare payment for OPPTS are found below:

- **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPTS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPTS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPTS Addenda, Addendum, D1.

The services in dispute have the following status indicator:

- Procedure code 36415 has status indicator “N” which is described as – “Items and services packaged into APC rates. Paid under OPPTS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.” The carrier denied the services as “This is a packaged item. Services or procedures included in the APC rate, but not paid separately.” Based on the status indicator, the carrier’s denial is supported.

- Procedure code 85027 has status indicator “N” which is described as – “Items and services packaged into APC rates. Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.” The carrier denied the services as “This is a packaged item. Services or procedures included in the APC rate, but not paid separately.” Based on the status indicator, the carrier’s denial is supported.
- Procedure code 80053 has status indicator “N” which is described as – “Items and services packaged into APC rates. Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.” The carrier denied the services as “This is a packaged item. Services or procedures included in the APC rate, but not paid separately.” Based on the status indicator, the carrier’s denial is supported.

2. Based on the provisions of Rule 134.403 the Division finds the carrier’s non-payment is supported by the applicable Medicare policy. No additional payment 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 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 17, 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.