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
Doctors Hospital Renaissance

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-17-2866-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 30, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $198.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 15, 2017	72070	$198.76	$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 seta out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:

- 00223 – (P12) Workers' compensation jurisdictional fee schedule adjustment
- P12 – Workers' compensation jurisdictional fee schedule adjustment

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- P300 – The amount paid reflects a fee schedule reduction
- W3 – Request for reconsideration
- MOPS – Services reduced to the Outpatient Prospective Payment System

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking $198.76 for Code 72070 rendered on February 15, 2017 in an outpatient hospital setting.

   The insurance carrier denied disputed services with claim adjustment reason code 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 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

   Review of 2017 Addendum B at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html finds the following;

   > Code 72070 – X-ray exam thorac spine 2vws, has a status indicator of Q1. This status indicator is defined as:
   >
   > Q1 – STV-Packaged Codes – Paid under OPPS: Addendum B displays APC assignments when services are separately payable.
   > (1) Packed APC payment if billed on the same claim as a HCPCS code assigned status indicator "S," "T," or "V."
   > (2) Composite APC payment if billed with specific combinations of services based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services.
   > (3) In other circumstances, payment is made through a separate APC payment

The medical claim contained another claim line with Code 72128 – "CT chest spine w/o dye." This code has a status indicator of Q3 – "Codes that may be paid through a composite APC." However as only a single CT procedure was performed rather than a combination, the composite specific criteria was not met. Therefore, based on the APC of 5522 found at www.cms.gov, Addendum A, the Status Indicator is classified as "S."

Based on the applicable Medicare payment policy for Code 72070 the carrier's denial is supported. No additional payment is due.

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		June 23, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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. **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.