TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Texas Health HEB

**Respondent Name**
Indemnity Insurance Co of North America

**MFDR Tracking Number**
M4-18-3253-01

**Carrier's Austin Representative**
Box Number 15

**MFDR Date Received**
May 9, 2018

## *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 as there are not S, T, or V status indicators used for the code to be bundled into."

**Amount in Dispute:** $116.98

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "…we have escalated the bills in question for bill review audit and payment. Supplemental response will be provided once the bill auditing company has finalized their review."

**Response Submitted by:** Gallagher Bassett

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 11, 2017 | 71010 | $116.98 | $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 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment

codes:

- MJ1N – Recommended reimbursement is based on CMS Hospital Outpatient status indicator J1: Complexity Adjustment
- P12 – Workers' compensation jurisdictional fee schedule adjustment

**Issues**

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

**Findings**

1. The requestor is seeking additional reimbursement for outpatient hospital services rendered on July 11, 2017 in the amount of $116.98. The insurance carrier denied disputed services with claim adjustment reason code MJ1N – "Recommended reimbursement is based on CMS Hospital Outpatient status indicator J1: Complexity Adjustment

   28 Texas Administrative Code §134.403 (b) 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 the applicable Medicare payment policy found at www.cms.gov, Claims Processing Manual, Chapter 4, Section 10.1.1 states,

   > *An OPPS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS 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 OPPS or under another payment system or fee schedule.*

   The submitted medical bill contained the following codes which are assigned the indicated Status Indicators,

   - Procedure code 71010 has status indicator Q3 which is defined as - *Codes that may be paid through a composite APC. In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.*

   Review of the entire medical bill finds code 49560 has a status indicator of J1 which is defined as – *Hospital Part B Services paid through a comprehensive APC. Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS SI = F,G,H,L and U"*

   Based on the above, the carrier's denial is supported as the service in dispute is not an exception to comprehensive packaging. 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 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**

| | | |
|---|---|---|
| | | August 2, 2018 |
| 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**.