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 Dallas

Respondent Name
City of Dallas

MFDR Tracking Number
M4-18-3254-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
May 9, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…as the 99283 has the modifier 25, this should allow the 73110 to be processed and paid. Please note per the NCCI Edits this line is not bundled and we show should have processed for payment as there are no S, T, or V status indicators used for the code to be bundled into."

Amount in Dispute: $118.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The charge for the services represented by the code are included/bundled into the total facility payment and do not warrant a separate payment the status indicator Q1 determines the service is packaged or excluded from payment."

Response Submitted by: Injury Management Organization, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 20, 2017	73130	$118.24	$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:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- 4915 – The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is package or excluded from payment.

Issues

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

Findings

1. The requestor's submitted DWC060 is requesting $118.24, Date of service June 20, 2017 for code 73130. The insurance carrier reduced the 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 the applicable Medicare payment policy found at, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates-Items/2017-April-Addendum-B.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending, find the status indicator for the code for the service in dispute 73130 is Q1 – "Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "S," "T," or "V."

   While the requestor states, "…there are no S, T, or V status indicators used for the code to be bundled into." Review of the entire claim shows the code 99283 was also submitted on this date of service. This code has a status indicator of J2. However, if the criteria for the J2 "Comprehensive Observation Services" is not met, the APC assigned to this code is 5023. The APC 5023 has a status indicator or "V."

   As the criteria for J2 "Comprehensive Observation Services" found at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9486.pdf, i.e., "…non-surgical encounter by a hospital in conjunction with observation services of eight or more hours" is not met the Status Indicator of "V" applies.

   The insurance carrier's reduction of payment is supported. Additional reimbursement cannot 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 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

Signature	Medical Fee Dispute Resolution Officer	May 24, 2018 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.