TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health Plano

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-18-4535-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
July 30, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $3,908.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This bill has already been reimbursed at the correct amount. Please note the Requestor submitted the original bill and then three request for reconsideration. This matter was been correctly reimbursed per the Texas Fee Schedule."

Response Submitted by: White Espey PLLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15 -16, 2017	97161, 99284, 96375, 96374, 96372	$3,908.10	$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 acute care hospital fee guideline for outpatient 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

- 954 – The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance

Issues

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

Findings

1. The requestor is seeking reimbursement of Procedure codes 97161, 99284, 96375, 96374 and 96372 rendered on August 15 -16, 2017 rendered during outpatient hospital stay.

   The insurance carrier denied disputed services with claim adjustment reason code 97 – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" and 954 – "The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance."

   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

   The applicable Medicare payment policy is found at www.cms.gov in the Medicare Claims Processing Manual, Chapter 4, Section 10.4 C, 7 which states in pertinent part,

   > *J2 services are assigned to comprehensive APCs when a specific combination of services are reported on the claim. Payment for all adjunctive services reported on the same claim as a J2 service is packaged into payment for the J2 service when certain conditions are met.*

   The certain conditions are detailed in Med Learn Matters Number MM9486 also at www.cms.gov and states in pertinent part,

   > *Any clinic visit, Type A Emergency Department (ED) visit, Type B ED visit, critical care visit, or direct referral for observation services furnished in a non-surgical encounter by a hospital in conjunction with observation services of eight or more hours, will qualify for comprehensive payment through APC 8011.*

   Review of the submitted medical bill finds emergency room services where billed in conjunction with 28 hours of observation services. Therefore the criteria for J2 comprehensive APC was met and the services in dispute are considered adjunctive or included services.

   The insurance carrier's denial reason 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	September 14, 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.