



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 Fort Worth

Respondent Name

Phoenix Insurance Co

MFDR Tracking Number

M4-19-2036-01

Carrier's Austin Representative

Box Number 5

MFDR Date Received

December 10, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Rule 134.403 section E all HCPC's that are paid per the fee schedule should pay per the APC allowable at 200 % regardless of the billed charges..."

Amount in Dispute: \$104.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider contends they are entitled to additional reimbursement for CPT codes 24342 (reinsertion of ruptured tendon) and J8501 (oral drug administration). The Carrier has reviewed the documentation and determined the Provider was properly reimbursed."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 12, 2018	Outpatient Hospital Services	\$104.51	\$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 outpatient hospital services.
- 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

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?

Findings

1. The requestor is seeking additional reimbursement in the amount of \$104.52 for Code J8501 rendered on June 12, 2018.

The insurance carrier reduced 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.”

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 Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1. which states in pertinent part,

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 disputed service Code J8501 – “Aprepitant, oral, 5 mg” has a status indicator of “K which is defined as NonPass-Through Drugs and Nonimplantable Biologicals, paid under OPPS; separate APC payments.

However, the status indicator of the billed Code 24342 is “J1 – Hospital Part B services paid through a comprehensive APC; 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...”

Code J8501 status indicator of “K” is not a listed exception, the carrier’s denial is supported. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has 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 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$0.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

January 4, 2019

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.