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
Doctor's Hospital at Renaissance

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-19-0670-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 8, 2018

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: $1,294.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company has determined that the allowable is correct and the provider is not due any additional monies."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 11 – 12, 2018	Outpatient Hospital Services	$1,294.62	$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 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Issues

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

Findings

1. The requestor is seeking additional reimbursement in the amount of $1,294.62 for outpatient hospital services rendered on July 11 – 12, 2018. The insurance carrier reduced 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 TAC §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. The application of this payment policy is discussed below.

   - Procedure code 26765 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (**except those with status F, G, H, L or U**; certain inpatient and preventive services; ambulance and mammography).
   - Procedure codes 11760, 11010 have status indicators of "T" and 96374 has a status indicator of "S". As seen above these are not exempt from the packaging requirement. Reimbursement is included with payment for the primary procedure. Separate payment is not 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

		November 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.