



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 of Cleburne

Respondent Name

Insurance Co of the State of PA

MFDR Tracking Number

M4-19-0714

Carrier's Austin Representative

Box Number 19

MFDR Date Received

October 9, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We show that the 12011 are not bundled and should have processed for payment as we feel the highest Q1 should have processed for payment..."

Amount in Dispute: \$330.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider is not entitled to medical fee dispute resolution through the DWC-60 process. Specifically, the Medical Review Division handles Medical Fee Disputes that involve an amount of payment of non-network healthcare. However, the healthcare involved is in the Coventry Healthcare Network. ...Since the claimant is in the Coventry Healthcare Network, the Medical Review Division does not have jurisdiction to resolve the medical fee dispute."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 28, 2018	Outpatient Hospital Services	\$330.52	\$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 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Issues

1. Did the insurance carrier raise a new issue?
2. What is the applicable rule for determining reimbursement for the disputed services?

Findings

1. The respondent states, "Since the claimant is in the Coventry Healthcare Network, the Medical Review Division does not have jurisdiction to resolve the medical fee dispute."

28 Texas Administrative Code 133.307 (d) (2) (F) states,

(F) The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section.

Review of the submitted explanations of benefits found no mention of Coventry Healthcare Network or a reduction based on a network. The carrier's position will not be considered in this review.

2. The requestor is seeking additional reimbursement in the amount of \$330.52 for outpatient hospital services rendered on March 28, 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 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. 10.1.1 *An OPPTS 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 OPPTS 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 OPPTS or under another payment system or fee schedule.*

Review of the submitted medical bill found the following;

- Procedure code 99284 has a status indicator of J2 if eight or more observation services are provided but as these services were not provided, APC is 5024 which has an assigned status indicator of "V."
- Procedure code 12011 has a status indicator of Q1 which is defined as, Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "S," "T," or "V."

The carrier's denial is supported 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

Signature

Medical Fee Dispute Resolution Officer

February 7, 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.