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
Lockheed Martin Corp

MFDR Tracking Number
M4-19-0718-01

Carrier's Austin Representative
Box Number 60

MFDR Date Received
October 9, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note per the NCCI Edits tis line is not bundled and we show should have processed for payment as there are not S. T U or V status indicators used for the code to be bundled into."

Amount in Dispute: $299.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of MDR the bill was sent for reconsideration. We are standing on our denial."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 11, 2017	Outpatient Hospital Services	$299.22	$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
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly

Issues

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

Findings

1. The requestor is seeking additional reimbursement of $299.22 for code 12002 billed as part of an outpatient hospital emergency room service billed on October 11, 2017. The requestor states, "…there are not S T U or V status indicators used for the code to be bundled into." 28 TAC § 134.403 (a) (3) states,

   > "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   Review of the submitted medical bill finds the following:

   - Procedure code 12002 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is paid separately only if OPPS criteria are met.

   - Procedure code 99284 has status indicator J2, for outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed). However, the criteria for comprehensive packaging is not met. Therefore, this code is assigned APC 5024 which per the 2017 Addenda A found at, the CMS link https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1656-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending, has a status indicator of "V".

     The requestor's position is not supported. Procedure code 12002 is packaged into Code 99284. 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.

Signature	Medical Fee Dispute Resolution Officer	November 2, 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.