



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 Alliance

Respondent Name

New Hampshire Insurance Co

MFDR Tracking Number

M4-19-0924-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

October 16, 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: \$121.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In reviewing the report, it is the carrier's position that this bill was paid correctly."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: April 11, 2018, Outpatient Hospital Services, \$121.43, \$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:
- 1 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 3 - The service is considered incidental, packaged, or bundled into another service or APC payment

Issues

- 1. Are the insurance carrier’s reasons for denial of payment supported?

Findings

- 1. The requestor is seeking reimbursement in the amount of \$121.43 for outpatient hospital services rendered on April 11, 2018. The insurance carrier reduced disputed services with claim adjustment reason code 1 – “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

Medicare’s Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) and Status Indicator for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. 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 Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates and Status Indicators in the OPPS final rules, available from www.cms.gov.

Review of the April 2018, Addenda B found the disputed service Code 73610 has a status indicator of Q1 – “STV – Packaged codes, (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “S,” “T,” or “V.” Code 99283 has a status indicator of J2 if the criteria for comprehensive observation services are met. However, the criteria (Emergency Department Visit in conjunction with observation services of eight or more hours) is not met. The status indicator is then “V.” Based on the status indicator of Q1 for the disputed code 73610, 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

November 9, 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.