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
California Insurance Company

MFDR Tracking Number
M4-19-2264-01

Carrier's Austin Representative
Box Number 6

MFDR Date Received
December 19, 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 refenced patient does not comply with Chapters 134.403 and 134.404."

Amount in Dispute: $726.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 3, 2018	Outpatient Hospital Services	$726.96	$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:
   - 785 – No separate reimbursement, items and/or services are packaged into the APC rate
   - 197 – Payment is included in the allowance for another service/procedure
   - 720 – Request for reconsideration reviewed. No further payment recommended. Denial letter sent under separate cover

Issues

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

Findings

The requestor is seeking additional reimbursement in the amount of $726.96 for outpatient hospital services rendered on May 3, 2018. The insurance carrier reduced disputed services with claim adjustment reason code 785 – "No separate reimbursement, items and/or services are packaged into the APC rate" and 197 – "Payment is included in the allowance for another service/procedure."

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 10.1.1 - Payment Status Indicators

> *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.*

Review of the submitted medical bill finds the status indicators as follows:

- Procedure code 99284 has status indicator J2, for outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed. Review of the submitted medical bill found 13 units of G0378 or observation was billed. This meets the criteria for comprehensive package. This code is assigned APC 8011. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPPS SI=F,G,H,L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.
- Procedure code 97161 has a status indicator of A. Reimbursement for this is included with payment for the primary procedure as this is not an exception as shown above.
- Procedure code 97165 has a status indicator of A. Reimbursement for this is included with payment for the primary procedure as this is not an exception as shown above.
- Procedure code 96374 has a status indicator of S. Reimbursement for this is included with payment for the primary procedure as this is not an exception as shown above.

The insurance carrier's reduction 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 15, 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.