



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 Plano

Respondent Name

Hartford Casualty Insurance Co

MFDR Tracking Number

M4-19-4229-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

May 23, 2019

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: \$1,341.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Medicare rules apply in the state of Texas which means the following guidelines support the bundling... J2 Status indicator: Hospital Part B services that may be paid through Comprehensive APC."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 12 – 13, 2019	Outpatient Hospital Services	\$1,341.20	\$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 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- 4915 – The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment
- P12 – Workers’ compensation jurisdictional fee schedule adjustment

Issues

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

Findings

1. The requestor is seeking additional reimbursement in the amount of \$1,341.20 for outpatient hospital services rendered January 12 – 13, 2019. The insurance carrier reduced disputed services based on bundling of services.

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 following: Procedure code 99285 has status indicator **J2** that is defined as, *“Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. 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 status indicator of “F”, “G”, “H”, “L” and “U”; ambulance services, diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.*

The codes in dispute have the following status indicators:

- 72131 – “S”
- 96375 – “S”
- 96365 – “S”
- 72148 – “S”

These codes are not exempt from the packaging requirement of the applicable Medicare payment policy. 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

June 14, 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.