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
Doctors Hospital at Renaissance

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-4811-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 8, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishi§134.403 he MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $2,667.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual adjudicated the bill, taking into account the requestor's wage index, and ultimately paid $4,687.59 for code 26765."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 4, 2019	Outpatient Hospital Services	$2,667.40	$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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service

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 $2,667.40 for outpatient hospital services rendered on April 4, 2019. The insurance carrier reduced disputed services based on workers compensation fee schedule and packaging rules.

   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.*

   The HCPCS codes in dispute are 11010, 14040, 11760 and 96374 which are assigned the following status indicators:

   - Procedure code 11010 has a status indicator of T.
   - Procedure code 14040 has a status indicator of T.
   - Procedure code 11760 has a status indicator of T.
   - Procedure code 96374 has a status indicator of S.

   Each of these codes would normally be paid if not billed with services that have a J1 status indicator. The medical bill submitted for this claimant include Procedure code 26765 which has a status indicator of J1 that is considered a comprehensive code that "packages all covered Part B services on the claim with the primary "J1" service for the claim." Based on the applicable Medicare payment policy regarding packaging the codes in dispute are not separately payable. 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	August 9, 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.