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
UT Health Quitman

Respondent Name
Tx Assoc of Counties Rmp

MFDR Tracking Number
M4-19-5018-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 29, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This bill has been underpaid. Critical Access Hospital Rates are charges x 30%."

Amount in Dispute: $650.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "These lab codes packaged to ER visit CPT 99281/450."

Response Submitted by: York

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 7, 2019	Clinical laboratory charges	$650.91	$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 fee guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 109 – Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
   - 97 – The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated
   - 193 – Original payment decision is being maintained

Issues

1. Is the insurance carrier's reasons for denial supported?

Findings

1. The requestor is seeking reimbursement for clinical laboratory services provided during an emergency room visit on May 7, 2019

   The insurance carrier denied disputed services stating these services are included in another provided service.

   Review of the applicable Division Rule of 28 TAC 134.403 (d) requires system Texas worker's compensation system participants to apply the Medicare payment policies in effect on the date a service is provided.

   The applicable Medicare payment policy is found in the Medicare Claims Processing Manual, Chapter 4, Section 10.1.1 at www.cms.gov, specifically "Status Indicators."

   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 health care provider submitted the codes listed below. Each code's status indicator found in Addenda B at www.cms.gov, is as follows:

   - 86705 Status indicator Q4
   - 86689 -90 Status indicator Q4
   - 86706 -90 Status indicator Q4
   - 86708 Status indicator Q4
   - 86803 Status indicator Q4
   - 87340 Status indicator Q4
   - 99281 Status indicator J2

The definition of status indicator Q4 is, (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned published and status indicator "J1", "J2", "S", "T", "V", "Q1", "Q2", OR "Q3."

Based on the status indicator of code 99281 being J2, and the status indicator of the codes listed on the DWC60 is Q4, the insurance carrier's denial is supported. No payment is recommended.

Conclusion

For the reasons stated above, DWC 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	September 26, 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 DWC 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.