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
M4-19-5039-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 30, 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: $634.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After review, York stood upon original audit results as these codes have a Q4 status and the codes are packaged to the ER visit code of 99281/450."

Response Submitted by: York

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 7, 2019	Outpatient Hospital Services	$634.96	$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 or denied the payment for the disputed services with the following claim adjustment codes:
   - 97 – The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated
   - 109 – Claim/service not covered by this contractor

Issues

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

Findings

The requestor is seeking additional reimbursement in the amount of $634.96 for outpatient hospital services rendered on May 7, 2019. The insurance carrier denied the disputed services based on packaging.

28 TAC §134.403 (d) requires Texas workers' compensation system participants to apply Medicare payment policies when coding, billing, reporting and reimbursement that are in effect on the date of service.

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. Specifically, Payment 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.

Review of the disputed codes of 86705, 86689 -90, 86706 -90, 86708, 86803, 87340 found each of these codes have a status indicator of Q4 which is defined as, "Packaged APC payment if billed on the same claim as a HCPCS code assigned published status indicator "J1","J2", "S", "T" ,"V", "Q1" ,"Q2", or "Q3".

These services were billed with Code 99281 which has a status indicator of "J2."

Based on the above, the insurance carrier's denial is supported. No additional 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, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute

Authorized Signature

		Ocotber 3, 2019
Signature	Medical Fee Dispute Resolution Officer	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 DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.