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 Tyler

**Respondent Name**
American Zurich Insurance Co

**MFDR Tracking Number**
M4-20-0003-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
September 3, 2019

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "This bill has been underpaid."

**Amount in Dispute:** $157.23

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The carrier's position remains consistent with its EOB."

**Response Submitted by:** Flahive, Ogden and Latson

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 23, 2019 | Outpatient Hospital Services | $157.23 | $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:
   - 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

**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 $157.23 for Code 97605 rendered on May 23, 2019. The insurance carrier reduced the disputed services based on packaging and the workers' compensation fee schedule.

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

   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.

   - Procedure code 15004 has status indicator T, while not in dispute, this code determines if other services are separately payable.
   - Procedure code 97605 has status indicator Q1, for STV-packaged codes. Reimbursement is packaged with payment for any service assigned status indicator S, T or V.

     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

| | | |
|---|---|---|
| | | October 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**.