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
Sompo America Insurance Co

MFDR Tracking Number
M4-20-0073-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 12, 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: $1,362.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider has already been paid pursuant to the Medical Fee Guidelines. Reimbursement was reduced to the Outpatient Prospective Payment System (OPPS). No additional allowance is owed."

Response Submitted by: Flahive, Ogden and Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 21, 2018	70498, 96374	$1,362.93	$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:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - P12 – Workers' compensation jurisdiction fee schedule adjustment

Issues

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

Findings

The requestor is seeking additional reimbursement in the amount of $1,362.93 for outpatient hospital services rendered on September 21, 2018. The insurance carrier reduced disputed services based on workers' compensation jurisdiction fee schedule.

28 TAC §134.403 (d) requires system participants to apply Medicare payment policies in effect on the date of services are 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 specifically payment status indicators. These indicators determine whether payment is made separately or packaged, and if the code is paid under OPPS or under another payment or fee schedule.

Review of status indicators on the submitted medical bill found the health care services provided included code 99285 or Emergency Department Visit in combination with 18 hours of G0378 or observation. This combination results in a comprehensive APC ranking of 8011 which per Addenda A of the Medicare Outpatient OPPS updates has a status indicator of J1.

The J1 Status Indicator definition is, "all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS SI=F,G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services."

- Procedure code 70498 has a status indicator of Q3. As seen above, this is not an exception to packaging. No separate payment recommended.
- Procedure code 96374 has a status indicator of S. As seen above, this is not exempt from packaging. No separate payment 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

Signature	Medical Fee Dispute Resolution Officer	October 24, 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 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.