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
Odessa Regional Medical Center

Respondent Name
Travelers Indemnity Co

MFDR Tracking Number
M4-20-0540-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
October 23, 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: $489.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the documentation and determined the Provider was properly reimbursed."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 21, 2019	Outpatient Hospital Services	$489.46	$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 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Issues

1. Is the insurance carrier's denial of the dispute services supported?

Findings

1. The requestor is seeking additional reimbursement in the amount of $489.46 for outpatient hospital services rendered on May 21, 2019. The insurance carrier denied the disputed services based on packaging.

   28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies 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 submitted codes on the medical bill finds;

   - Procedure code 73130 has status indicator Q1 and is packaged into code 13131.
   - Procedure code 13131 has status indicator of T. The OPPS Addendum A rate is $314.08, multiplied by 60% for an unadjusted labor amount of $188.45, in turn multiplied by the facility wage index of 0.8969 for an adjusted labor amount of $169.02. The non-labor portion is 40% of the APC rate, or $125.63. The sum of the labor and non-labor portions is $294.65. The Medicare facility specific amount of $294.65 is multiplied by 200% for a MAR of $589.30.
   - Procedure code 90471 has status indicator Q1 and is packaged into code 13131.
   - Code 96365 has a CCI edit with Code 13131. The health care provider used an XU modifier to indicate overlapping procedure. Use of this modifier was not supported based on the submitted documentation.
   - Code 96375 has a CCI edit with Code 13131. The health care provider used an XU modifier to indicate overlapping procedure. Use of this modifier was not supported based on the submitted documentation.
   - Procedure code 99284 has status indicator of V as the J2 criteria for comprehensive observation was not met and is assigned APC 5024. The OPPS Addendum A rate is $360.37, multiplied by 60% for an unadjusted labor amount of $216.22, in turn multiplied by the facility wage index of 0.8969 for an adjusted labor amount of $193.93. The non-labor portion is 40% of the APC rate, or $144.15. The sum of the labor and non-labor portions is $338.08. The Medicare facility specific amount of $338.08 is multiplied by 200% for a MAR of $676.16.
   - Procedure code 90715 has status indicator N, reimbursement is included with payment for the primary services.
   - Procedure code J0171 has status indicator N, reimbursement is included with payment for the primary services.
   - Procedure code J0690 has status indicator N, reimbursement is included with payment for the primary services.

2. The total recommended reimbursement for the disputed services is $1,265.46. The insurance carrier paid $1,265.46. Additional payment is not recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment 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	November 21, 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.