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 Fort Worth

Respondent Name
Hartford Casualty Insurance Co

MFDR Tracking Number
M4-20-0595-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 31, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the EOB the carrier bundled this code, however 99283 has a J2 status indicator and the only other payable code is a Q1 status indicator. A J2 does not bundle into a Q1 as it is the primary procedure."

Amount in Dispute: $428.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation shows the original bill was processed correctly with no additional allowance."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 18, 2018	Outpatient Hospital Services	$428.63	$428.63

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

- 906 – In accordance with clinical based coding edits component code of comprehensive medicine evaluation and management services

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $428.63 for outpatient hospital services rendered on November 18, 2018. The insurance carrier denied the disputed services based on bundling and CCI edits.

   28 TAC §134.403 (d) requires Texas workers' compensation system participants to apply Medicare payment policies that are 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.

   Review of the applicable Medicare OPPS Addenda finds the following:

   - Procedure Code 99283 has a status indicator of J2 only if billed in conjunction with 8 hours of more of observation if not, this code is assigned APC 5024 with a status indicator of V
   - Procedure Code 90471 has a status indicator of Q1 which is bundled into any other code with a S, T, or V status indicators.

   Based on the above the denial of code 99283 is not supported. The applicable fee guideline is found below.

2. 28 TAC §134.403, (f) details when separate reimbursement of implant is not requested, the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts (if applicable) determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register* multiplied by 200 percent.

   The maximum allowable reimbursement per the above is calculated as follows:

   - Review of the Medicare OPPS Addenda A shows procedure code 99283 is assigned APC 5024 and has a status indicator of V.

     The OPPS Addendum A rate is $355.53, multiplied by 60% for an unadjusted labor amount of $213.32, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of $207.69.

     The non-labor portion is 40% of the APC rate, or $142.21.

     The sum of the labor and non-labor portions is $349.90. The cost of services does not exceed the threshold for outlier payment.

     The Medicare facility specific amount of $349.90 is multiplied by 200% for a MAR of $699.80.

   - Procedure code 90471 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V.

2. The total recommended reimbursement for the disputed services is $699.80. The insurance carrier paid $112.46. The requestor is seeking additional reimbursement of $428.63. This amount is 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 established payment is due. As a result, the amount ordered is $428.63.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is/is not entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $428.63, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 11, 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.