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 Alliance

Respondent Name
Illinois National Insurance Co

MFDR Tracking Number
M4-20-0782-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 25, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DOS not paid."

Amount in Dispute: $368.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: None submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 25, 2019	Outpatient Hospital Services	$368.23	$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:
   - 1 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 2 – Workers' Compensation Medical Treatment Guideline Adjustment
   - 3 – The service is considered incidental, packaged, or bundled into another service or APC payment
   - 4 – No additional reimbursement allowed after review of appeal/reconsideration

Issues

1. Is the insurance carrier's denial supported?

Findings

1. The requestor is seeking additional reimbursement in the amount of $368.23 for outpatient hospital services rendered on April 25, 2019. The insurance carrier denied the disputed services based on services included in another procedure.

   28 TAC §134.403 (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

   28 TAC §134.403 (b)(3) states "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   Review of the CMS National Correct Coding Initiative Edits found an edit exists between Code 96360 which is in dispute and Code 99284.

   Per this edit separate allowance is not made unless supported by documentation that indicates a separate and distinct procedure. Review of the submitted documentation did not find evidence to support a separate and distinct service. The insurance carrier's denial is supported.

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

		January 23, 2020
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.