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
Doctor's Hospital at Renaissance

Respondent Name
XL Specialty Insurance Co

MFDR Tracking Number
M4-20-1842-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 31, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the account we have concluded that reimbursement received was inaccurate."

Amount in Dispute: $618.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…It appears that the provider is now adding modifier 25 to CPT code 99284. However, that modifier was not on the provider's original medical bill nor in the provider's request for reconsideration. It was not on the provider's UB-04s. …The provider is not entitled to any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 25, 2019	Outpatient Hospital Services	$618.58	$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 jurisdiction fee schedule adjustment

- 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 (National Correct Coding Initiative/outpatient code editor) component code of comprehensive medicine, evaluation and management services procedure (9000-99999) has been disallowed
- 954 – The allowance for normally package revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance

Issues

1. Is the insurance carrier's denial supported?
2. What is the applicable rule for determining reimbursement for the disputed services?

Findings

1. The requestor is seeking additional reimbursement in the amount of $618.58 for outpatient hospital services rendered on December 25, 2019. The insurance carrier denied the dispute services based on Medicare Coding edits and reduced the charges based on workers compensation fee schedule.

   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.

   Review of the applicable Medicare NCCI edits found an edit does exist between code 94640 and code 99284. The insurance carrier's denial is supported. No reimbursement is recommended for code 99284.

2. 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.

   Review of the other disputed services found:

   - 94640 has a status indicator of Q1 or STV packaged service. This code is packaged into any code with status indicator S, T, or V. The submitted bill contained code 99284 which has a status indicator of V as the criteria for comprehensive observation was not met. No payment is recommended.
   - 99284 has a CCI edit. No payment is recommended.
   - 93005 has a status indicator of Q1 or STV packaged service. This code is packaged into any code with status indicator S, T, or V. The submitted bill contained code 99284 which has a status indicator of V as the criteria for comprehensive observation was not met. No payment 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 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	April 24, 2020 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.