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
Doctors Hospital at Renaissance

Respondent Name
TASB Risk Mgmt Fund

MFDR Tracking Number
M4-20-2206-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 5, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…there is a pending payment in the amount of $2,298.23."

Amount in Dispute: $2,480.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Fund has made total payments of $5,474.90 based on the maximum allowable reimbursement as per the OPPS fee guideline which indicates reimbursement should be 200% of Medicare's allowable unless separate reimbursement for implants is requested as per Rule 134.403(f)."

Response Submitted by: TASK Risk Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 6, 2020	Outpatient Hospital Services	$2,480.07	$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 is included in the allowance for another service/procedure
    - 193 – Original payment decision is being maintained
    - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is the insurance carrier's denial supported?

Findings

1. The requestor is seeking additional reimbursement in the amount of $2,480.07 for outpatient hospital services rendered on February 6, 2020. The insurance carrier reduced the disputed services based on bundling and 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.

   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 submitted DWC060 found only code 29880 and 96374 have amounts listed in dispute. These codes have the following status indicators:

   - Code 29880 has a status indicator of J1 as does Code 29879. Medicare policy found in the Medicare Claims Processing Manual, Chapter 4, Section 10.2.3 states, "*When multiple J1 services are reported on the same claim, the **single payment is based on the rate associated with the highest ranking J1 service**.*"

     Review of the "ranking" found that Code 29880 has a ranking of 1815. This ranking is lower than the ranking than the other J1 Code (29879) with a ranking of 1691. The insurance carrier's denial for bundling is supported. No additional payment is recommended.

   - Code 96374 has a status indicator of S. This code is packaged into code 29879 with a status indicator of J1 or comprehensive. The insurance carrier's denial for bundling is supported. No additional 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	May 29, 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.