



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

Bellaire Emergency Center

Respondent Name

Farmington Casualty Co

MFDR Tracking Number

M4-21-1311-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

March 26, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have asked for reconsideration on the charges for the above referenced patient as the carrier, Travelers, did not pay on numerous X-rays for this patient and we feel that coding is correct for additional payment on these lines."

Amount in Dispute: \$373.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the Medicare coding and reimbursement guidelines and contends the reimbursement is correct. The services at issue are all Q1 codes. When multiple Q1 codes are billed together, the single highest APC rate code is reimbursed."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 4, 2020	72040, 73562-59, 73610-59	\$373.80	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
- 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

- 4915 – The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.

Issues

Is the insurance carrier's denial supported?

Findings

The requestor is seeking additional reimbursement in the amount \$373.80 for outpatient hospital services rendered on September 4, 2020. The insurance carrier denied the disputed services based on bundling.

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 and Ambulatory Payment Category (APC). The payment status indicators of the disputed services are as follows.

- 72040 has a status indicator of Q1, STV packaged code. This code is packaged into the Code 99284 which has a status indicator of V. No additional payment is recommended.
- 73562-59 as above. No additional payment is recommended.
- 73610-59 as above. 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

April 30, 2021

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.