



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

Mastec Inc

MFDR Tracking Number

M4-21-1967-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

July 8, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule 134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount. After reviewing the account we have concluded that reimbursement received was inaccurate."

Amount in Dispute: \$2,685.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 1 – 4, 2021	Outpatient Hospital Services	\$2,685.24	\$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:
 - 236 – This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the NCCI edits or work comp state regs/fee schedule requirements.

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- P12 – Workers’ compensation jurisdictional fee schedule adjustment

Issues

What is the applicable rule for determining reimbursement for the disputed services?

Findings

The requestor is seeking additional reimbursement for outpatient hospital services rendered in February 2021. The insurance carrier reduced the disputed services based on packaging 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 and Ambulatory Payment Category (APC).

Review of the disputed services listed on the DWC060 as amounts due have been reviewed per the applicable Medicare payment policy and the results shown below.

- 29880 - Has a status indicator of J1 as does Code 29879. The applicable Medicare payment policy states in pertinent part when two codes with a J1 status indicator are submitted on the same medical claim the Code that has the highest ranking is paid. Code 29880 has a ranking of 2,148. Code 29879 has a ranking of 2,013 which is the highest ranking J1 code. The payment of Code 29879 is not in dispute. No payment is recommended for Code 29880.
- 96374 – Has a status indicator of S. The applicable Medicare payment policy states when a medical claim contains a J1 procedure code all other procedures are packaged into the payment of the J1 or comprehensive code. 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

July 26, 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.