TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Frisco Medical Center

Respondent Name
Travelers Indemnity Co

MFDR Tracking Number
M4-22-1224-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
February 22, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 26, 2021	87635	$102.62	$0.00

Requestor's Position

Our appeal was for an unpaid Covid test. We have attached a CMS ruling from April 14,2020 showing allowables for the required Covid testing due to the pandemic. Most other payor have been processing this charge at 200% of the allowables presented from Medicare. We are under the impression this charge is now payable and would like a decision as to who is correct.

Amount in Dispute: $102.62

Respondent's Position

The Carrier has reviewed the documentation and contends the Provider has been reimbursed at the appropriate amount. The primary code 63042 was reimbursed pursuant to the applicable Medicare base rate and Division outpatient modifier. This code has a status of J1, indicating that all other codes, including CPT code 87635, are inclusive o the primary coded procedure.

Response submitted by: Travelers

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.403 sets out the fee guidelines for outpatient hospital services.

Denial Reasons

The insurance carrier reduced 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.
- P12 – Workers' Compensation jurisdictional fee schedule adjustment.

Issues

1. What rule applies for determining reimbursement for the disputed services?

Findings

1. DWC Rule 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 submitted medical bill and the applicable fee guidelines referenced above is shown below.

   - Procedure code 87635 has status indicator A. The primary procedure code 63042 has a status indicator of J1. The definition of J1 found in the CMS Claims Processing Manual at www.cms.gov, states in pertinent part, Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS (HCPCS codes with status indicator A).

     The insurance carriers reduction is supported. No additional payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 21, 2022 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.