



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

Texas Mutual Insurance Co

MFDR Tracking Number

M4-17-3872-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

August 30, 2017

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."

Amount in Dispute: \$1,042.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed code 94640, which has a status indicator (SI) "Q1." Addendum D1 indicates this code is packaged when a billed code with SI "S" is on the same bill. Code 96374 has SI "S." As a result Texas Mutual denied payment. Texas Mutual will pay the MAR for codes 96374 and 96375."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 31, 2017 through June 1, 2017	94640, 96374, 96375	\$1,042.32	\$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 payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers' compensation jurisdictional fee schedule adjustment
 - 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service

- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
- 724 – No additional payment after a reconsideration of services.

Issues

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking additional reimbursement for the following codes:

- 94640 – Air way inhalation treatment
- 96374 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
- 96375 – Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)

The insurance carrier denied disputed services with claim adjustment reason codes 618 – “The value of this procedure is packaged into the payment of other services performed on the same date of service.”

28 Texas Administrative Code §134.403 (d) states in pertinent part,

For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

Review of the Medicare Claims Processing Manual, Chapter 4, Section 10.2.3 at www.cms.gov, states in pertinent part,

Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service. With few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.

Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:

- *major OPPS procedure codes (status indicators P, S, T, V)*

The medical bill contained CPT Codes 29827 –LT. While codes 29827 –LT is not in dispute per Addendum B at www.cms.gov, the assigned status indicator is J1. Based on the applicable Medicare payment policy this status indicator impacts the services in dispute as shown below.

The services in dispute have the following status indicators:

- 94640 – Status Indicator “Q1” which has a definition of “Packaged APC payment if billed on the same date of service as a HCPCS code assigned indicator “S,” “T,” or “V.” Based on the applicable Medicare payment policy this procedure is packaged therefore, the carrier’s denial is supported.
- 96374 – Status Indicator “S.” Based on the applicable Medicare payment policy this procedure is packaged therefore, the carrier’s denial is supported.
- 96375 – Status Indicator “S.” Based on the applicable Medicare payment policy this procedure is packaged therefore, the carrier’s denial is supported.

The Division has reviewed the applicable Medicare payment policy as defined by 28 Texas Administrative Code §134.403 (d) and found no additional reimbursement is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement 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 determined the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 13, 2017 Date
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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 the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.