



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Texas Health Huguley

Respondent Name

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-24-2450-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

July 3, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 8, 2024	73590	\$166.73	\$0.00
March 8, 2024	71101	\$201.73	\$0.00
Total		\$368.46	\$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of a document titled, "Reconsideration" that states, ..."Please re-review CPTs 73590 and 71101 as these were denied as bundled services, however neither should be considered bundled as their status indicators allow for payment with other services billed."

Amount in Dispute: \$368.46

Respondent's Position

"The bill related to the above captioned MDR has been sent to bill review. As soon as it has been processed an addendum response will be issued."

Supplemental response submitted July 26, 2024

"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

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 Texas Administrative Code \(TAC\) §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 or denied the disputed service(s) with the following claim adjustment codes.

- 1 – Original DCN 600875060
- 2 – This procedure on this date was previously reviewed (148)
- 18 – Duplicate claim/service. (ANSI118)
- 4 – Rush bill (E328)
- 167 – This (these) diagnosis(es) is (are) not covered. (ANSI167)
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. (ANSI197)
- P12 – Workers compensation jurisdictional fee schedule adjustment. (ANSIP12)
- ICD does not match D code (E322)
- 11 – A technical Bill Review (TBR) has been performed. (ETBR)
- M15 – Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed. (RARCM15).

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of Code 73590 – radiological examination tibia & fibula 2 views, and 71101 – unilateral radiologic examination of the ribs for date of service March 8, 2024. The insurance carrier denied the disputed service based on packaging.

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 applicable Addenda B at www.cms.gov found each of the disputed codes have a status indicator of Q1 – Packaged APC payment if billed on same date of service as a HCPCS assigned status indicator “S”, “T”, or “V”.

Review of the submitted bill found code 99284 was billed. This code has a J2 status indicator **ONLY** when submitted on a medical bill in conjunction with more than eight hours of observation. Otherwise, the assigned APC has a status indicator of “V”.

The DWC finds the insurance carrier’s packaging of the payment for these procedures into the primary “V” procedure 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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July 30, 2024
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 electrónico CompConnection@tdi.texas.gov.