



# Texas Department of Insurance

## Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645  
512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Houston Orthopedic & Spine Hospital

**Respondent Name**

Illinois National Insurance Co

**MFDR Tracking Number**

M4-15-1279-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

December 29, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The claim was denied due to provider's state license number is invalid. This has been corrected with correct billing license number located in box 57."

**Amount in Dispute:** \$635.84

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Based on the information received so far, the Carrier is maintaining their position that the requested \$635.84 is not owed to the requestor..."

**Response Submitted by:** AIG

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 11, 2014	Outpatient Hospital Services	\$635.84	\$0.00

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §133.10 sets out requirements related to billing forms and formats.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient facility services provided in an acute care hospital.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
  - 193 – Original payment decision is being maintained

#### **Issues**

- Did the requestor support claim was submitted in compliance with Division guidelines?
- What is the applicable rule pertaining to fee guidelines?

3. Is the requestor entitled to reimbursement?

### **Findings**

1. The carrier denied the disputed service as 16 – “Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.” 28 Texas Labor Code §133.10 (f) states in pertinent part, “All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form.” Rule 133.10 (2) states in pertinent part, “The following data content or data elements are required for a complete institutional medical bill related to Texas workers' compensation health care: (CC) billing provider's state license number (UB-04/field 57) is required when the billing provider has a state license number; the billing provider shall enter the license number and jurisdiction code (for example, '123TX');” Review of the corrected institutional bill finds;
  - a. Box 56 NPI – 1659313146 for Houston Orthopedic Surgical Hospital
  - b. Box 57 – 008319TX – NPI registry shows License number to be 008319 for the State of Texas

The Division finds the carrier's denial is not supported. The disputed services will be reviewed per applicable rules and fee guidelines.

2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
  - Procedure code 36415 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code 80048 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code 85730 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code 85025 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code 85610 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
3. The total allowable reimbursement for the services in dispute is \$0.00. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended

### **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 upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

March , 2015

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §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 MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **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.**