



# 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**

MHHS Northwest Hospital

**Respondent Name**

Hartford Underwriters Insurance

**MFDR Tracking Number**

M4-15-2158-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

March 16, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "CPT codes 99213 99214 are reimbursable under Medicare guidelines and we are seeking TDI to assist in having the carrier to issue payment."

**Amount in Dispute:** \$1,572.75

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Under OPSS, Medicare designates that services are either packaged into an ambulatory payment classification (APC) payment paid under another payment methodology, paid under an APC rate, or are not covered... Review of Rev Code 761 for clinic services shows it is not payable under Medicare OPSS."

**Response Submitted by:** The Hartford

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 21, 2014 – June 112, 2014	Outpatient Hospital Services	\$1,572.75	\$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.
- [Add any rules that are pertinent to or cited in the body of your decision, with a brief description (you don't have to quote the text of the rule here, just describe what the rule is about).]
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 797 – Service not paid under Medicare OPSS
  - 193 – Original payment decision is being maintained

**Issues**

- Did the requestor submit the claim within guidelines from the Division?

2. Is the requestor entitled to reimbursement?

**Findings**

1. The Carrier denied the disputed services as 797 – “Service not paid under Medicare OPPS.” 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,” Review of the submitted medical bill finds;

- a. The claim was submitted on UB-04 CMS 1450
- b. The type of bill was “131” or Outpatient Hospital Services

The carrier’s denial is supported as the codes submitted (99213 and 99214) have a Status Indicator of B which denotes codes that are not recognized by OPPS when submitted on an outpatient hospital bill. Please refer to [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/downloads/CMS1392P\\_Addendum\\_D1.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/downloads/CMS1392P_Addendum_D1.pdf) for a detailed description of status indicators that apply to Hospital Outpatient PPS. Revenue Code 250 or “Pharmacy” is not separately payable under applicable Medicare payment policies.

2. The total allowable reimbursement for the services in dispute is \$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	April 9, 2015 Date
-----------	--	-----------------------

**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.**