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
FROEDTERT MEMORIAL LUTHERAN HOSPITAL

Respondent Name
WAUSAU UNDERWRITERS INSURANCE COMPANY

MFDR Tracking Number
M4-18-2557-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
March 12, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this point, we feel we have no other choice than to appeal directly to Texas Dept. of Insurance. From the narrative, you can see our efforts on resolving the issues related to this claim."

Amount in Dispute: $49,620.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "According to Medicare OPPS fee schedule, CPT code 21142 is an inpatient only code. We denied CPT 21142 as 'According to CMS rules, Status Indicator C codes are not payable on OPPS. (ESOC)'. There was not a negotiated agreement with the provider."

Response Submitted by: Liberty Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 10, 2017	Outpatient Hospital Services	$49,620.39	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
3. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
   - U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES. (U634)
   - ESIC – ACCORDING TO CMS RULES, STATUS INDICATOR C CODES ARE NOT PAYABLE ON OPPS. (ESIC)
   - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
   - U301 – THIS ITEM HAS BEEN REVIEWED ON A PREVIOUSLY SUBMITTED BILL, OR IS CURRENTLY IN PROCESS. NOTIFICATION OF DECISION HAS BEEN PREVIOUSLY PROVIDED OR WILL BE ISSUED UPON COMPLETION OF OUR REVIEW. (U301)

Issues

1. Under what authority is this request for medical fee dispute resolution considered?
2. Has the requestor waived the right to medical fee dispute resolution?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Wisconsin to an injured employee subject to a Texas Workers' Compensation insurance claim. The health care provider has requested medical dispute resolution in accordance with Texas Labor Code Section 413.031(a)(1), which entitles a health care provider to a review of medical services if payment is reduced or denied. Because the requestor has sought the administrative remedy provided in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes it has jurisdiction to decide the medical fee issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable division rules.

2. 28 Texas Administrative Code §133.307(c)(1) requires that:

> A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
>
> (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The date of the services in dispute is January 10, 2017. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on March 12, 2018. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

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 determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	April 6, 2018
Signature	Medical Fee Dispute Resolution Officer	Date

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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.