



# 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

TEXAS SPINE AND JOINT HOSPITAL

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-19-3655-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

April 1, 2019

#### REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the coding is appropriate and CPT code 27096 is payable, as it was specifically authorized by Coventry. Second, the Hospital provided the medically necessary, authorized procedure and is entitled to reimbursement under the fee guidelines."

Amount in Dispute: \$7,470.07

#### RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The procedure code is 27096, SI joint injection. 2018 Addendum B indicates is a status indicator 'B,' which means it is not paid under OPPS."

Response Submitted by: Texas Mutual Insurance Company

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 4, 2018	Outpatient Hospital Services	\$7,470.07	\$0.00

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 §134.1 sets out general provisions regarding medical reimbursement.
- 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
  - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
  - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
  - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
  - DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (800) 859-5995 X3994.

- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 617 – THIS ITEM OR SERVICE IS NOT COVERED OR PAYABLE UNDER THE MEDICARE OUTPATIENT FEE SCHEDULE.
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.

### Issues

Is the requestor entitled to additional reimbursement?

### Findings

This dispute regards outpatient facility services subject to DWC’s *Hospital Facility Fee Guideline*, Rule §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors modified by DWC rules.

Reimbursement for the disputed services is calculated as follows:

- Procedure codes J2250, J1030 and J7030 have status indicator N for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- The primary procedure code 27096 has status indicator B, for codes not paid under OPPS—not used on an outpatient hospital bill (type 12x and 13x).

The hospital failed to bill a code that is payable under Medicare payment policies and thus does not have a maximum allowable reimbursement (MAR) that can be calculated under *Hospital Fee Guideline* Rule §134.403(f).

Rule §134.403(e)(3) provides that, in the absence of an applicable contract, if “an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).”

Payment is therefore subject to the general medical reimbursement provisions of 28 Texas Administrative Code §134.1(e), which requires that, in the absence of an applicable fee guideline or a negotiated contract, medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount as specified in Rule §134.1(f).

Rule §134.1(f) requires that fair and reasonable reimbursement shall:

- (1) be consistent with the criteria of Labor Code §413.011;
- (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
- (3) be based on nationally recognized published studies, published division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

Texas Labor Code §413.011(d) requires that:

Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

When a reimbursement has not been established, Rule §133.307(c)(2)(O) requires the requestor to provide: documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) . . . when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable

No documentation was presented to support that the reimbursement sought by the requestor is fair and reasonable in accordance with Rule §134.1. The requestor did not discuss, demonstrate or justify the payment amount sought. The requestor has the burden of proof to support by a preponderance of the evidence that payment is due. The requestor failed to meet that burden in this dispute. Payment cannot be recommended.

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 findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

The division concludes the requestor failed to establish 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 25, 2019
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 DWCO45M) in accordance with the form’s instructions. The division must receive the request within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 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.