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
Doctor's Hospital at Renaissance

Respondent Name
Hartford Underwriters Insurance Co

MFDR Tracking Number
M4-20-2967-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 19, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $210.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 99213 is a status B code and is bundled into the services performed on dos 04/24/20 by the same provider."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 29, 2020	Outpatient Hospital Services	$210.06	$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 §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:
    - 96 - Non-covered charge(s)
    - 133 – The disposition of this claim/service is pending further review
    - 797 – Service not paid under OPPS

Issues

What is the applicable rule for determining reimbursement for the disputed services?

Findings

The requestor is seeking reimbursement for services provided in an outpatient hospital on April 29, 2020.

The information on the DWC060 referenced code G0463. The medical bill indicates code 99213 was the code submitted and adjudicated by the insurance carrier on this date of service.

No reimbursement is recommended on the code submitted on the DWC060.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC 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.

For the reasons above the requestor has not established payment 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

		September 18, 2020
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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.