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
Baylor Orthopedic & Spine Hospital

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-21-1101-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 3, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per EOB expected reimbursement was partially paid. CPT codes 97116 and 97161 was not paid. The codes are not inclusive to any other code and should be paid separately."

Amount in Dispute: $394.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual paid the Outpatient Hospital Bill received from Baylor Ortho and Spine Hospital per OPPS/APC Fee Schedule and determined that physical therapy codes for this bill were audited correctly given the direction given by Addendum B,D1 and Rule 134.203. No addition payment is due."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 28, 2020	Outpatient Hospital Services	$394.06	$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:
    - P12 – Workers' compensation jurisdictional fee schedule adjustment
    - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was process properly
- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
- 617 – This item or service is not covered or payable under the Medicare outpatient fee schedule

Issues

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

Findings

The requestor is seeking additional reimbursement in the amount $394.06 for physical therapy services rendered during an outpatient hospital stay. The insurance carrier denied the disputed services as being bundled into the primary procedure.

28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

Review of the submitted medical bill found a claim line with HCPCS code 22551. This code has a status indicator of J1. The CMS Claims Processing Manual, Chapter Four, Section 10.2.3 states,

> Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:
>
> - major OPPS procedure codes (status indicators P, S, T, V)
> - lower ranked comprehensive procedure codes (status indicator J1)
> - non-pass-through drugs and biologicals (status indicator K)
> - blood products (status indicator R) DME (status indicator Y)
> - **therapy services (HCPCS codes with status indicator A reported on therapy revenue centers)**

The insurance carrier's denial is supported. No additional payment is recommended.

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

Signature	Medical Fee Dispute Resolution Officer	March 29, 2021 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.