



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

Utica Mutual Insurance Co

MFDR Tracking Number

M4-21-1420-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

April 14, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...our position is the bill is payable because this is the only bill representing the Hospital's charges for this procedure, and not bundled with any other procedures or payments."

Amount in Dispute: \$10,196.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per our bill review company, Genex, TX Outpatient is allowed per Medicare OPPS. CPT 27096 has a Status Indicator B which is Not paid under OPPS. Since this was the only CPT billed there isn't an allowance for this bill."

Response Submitted by: Utica National Insurance Group

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 3, 2020	Outpatient Hospital Services	\$10,196.45	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
- The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - P12 – Workers' compensation jurisdiction fee schedule adjustment

Issues

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

Findings

The requestor is seeking reimbursement in the amount \$10,196.45 for outpatient hospital services rendered on August 3, 2020. The insurance carrier denied the disputed services based on bundling.

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).

Procedure code 27096 has status indicator B, for codes not paid under OPPOS—these codes may not be reported on an outpatient hospital bill (type 12x and 13x). Payment is not 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/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

		May 28, 2021
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.