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 Surgical Hospital

Respondent Name
Travelers Indemnity Co of Connecticut

MFDR Tracking Number
M4-21-1462-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
April 20, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the EOB payment has been disallowed for CPT 27096 indicating that the CPT code is not payable per the OPPS. The CPT code 27096 is currently listed in the Texas Physician Medical Fee Schedule with an EXR of $178.31. We ask that you reprocess the invoice for payment based on the Texas Physician Medical Fee Schedule…."

Amount in Dispute: $356.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Under the Outpatient Prospective Payment System edits, services with status indicator B are not reimbursable under OPPS. CPT code 27096 has a status indicator of B."

Response Submitted by:

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 7, 2020	Outpatient Hospital Services	$356.62	$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)
    - 797 – Service not paid under Medicare OPPS

Issues

Is the insurance carriers' denial supported?

Findings

The requestor is seeking reimbursement in the amount $356.62 for outpatient hospital services rendered on in December 2020. The insurance carrier denied the disputed services as the procedure code is not covered under Medicare OPPS.

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 the health care provider submitted code 27096-LT and 27096-RT. This status indicator of this code is listed as "B" defined as "Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type. Not paid under OPPS."

Based on this review the outpatient hospital bill submission of Code 27096-LT and 27096-RT is not payable. No 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	May 21, 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.