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
M4-21-1680-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 21, 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 it not bundled with any other procedures or payments."

Amount in Dispute: May 21, 2021

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."

Response Submitted by: Utica National Insurance Corp

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 21, 2020	Outpatient Hospital Services	$10,103.95	$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:
    - 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

- P12 – Workers' compensation jurisdictional 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 $10,103.95 for outpatient hospital services rendered on December 21, 2020. The insurance carrier denied the disputed services based on packaging.

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). The Status Indicator for the disputed service is "B" which is defined as, "Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x)." Review of the submitted medical bill found the bill type was 131 or outpatient hospital. No payment for the disputed service can be 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	June 11, 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.