Texas Department of Insurance
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Oakbend Medical Center

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-21-1783-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 4, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was denied by Texas Mutual for the wrong bill type as this procedure was approved for Inpatient and it was performed on an outpatient basis. CPT 27132 was removed from the CMS Inpatient only list for calendar year 2020. We follow CMS guidelines and bill this as an outpatient surgery as appropriate."

Amount in Dispute: $98,877.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…The facility indicates CPT code 27132 was removed from the inpt list for CY2020. Texas Mutual reviewed the OPPS/APC Fee Schedule for CY2020. Per OPPS Addendum B cpt code 27132 is confirmed with a status indicate of "C", the definition for status indicator "C" listed in Addendum D1 indicates the procedure is not paid under OPPS, bill as inpatient. Billing from the facility is for outpatient services. Texas Mutual audited the bill in accordance with Rule 134.403 – Hospital Facility Fee Guideline-Outpatient and OPPS/APC Medicare Fee Guideline. No payment is due."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 12, 2020	Outpatient Hospital Services	$98,877.98	$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.
   - W3 – In accordance with TDI-DWC Rule 1134.804, this bill has been identified as a request for reconsideration or appeal.
   - DC4 – No additional reimbursement allowed after reconsideration.
   - 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestors' position statement supported?

Findings

The requestor is seeking reimbursement for outpatient hospital services rendered in June 2020. The insurance carrier states the primary procedure is identified as a code only payable when performed in an inpatient setting. The health care provider states the procedure was removed from the inpatient only list for CY2020.

Division Rule 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 Code 27132 as found in www.cms.gov, Addenda B for CY2020 is "C". Addenda D1 details this status indicator to mean "Inpatient Procedures, Not paid under OPPS. Admit patient. Bill as inpatient."

Addenda E for CY2020 found Code 27132 is listed as not covered.

	Addendum E.-HCPCS Codes That Will Be Paid Only as Inpatient Procedures for CY 2020		
	CPT codes and descriptions only are copyright 2019 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.		
HCPCS Code	**Short Descriptor**	**CI**	**SI**
27132	**Total hip arthroplasty**		**C**

The requestors' position is not supported. No reimbursement 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	July 6, 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.