TDI Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Protective Insurance Co

MFDR Tracking Number
M4-22-0492-01

Carrier's Austin Representative
Box Number 27

DWC Date Received
November 8, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 25, 2021	G0463	$213.48	$0.00
	Total	$213.48	$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "Per your EOR denial claim was billed with incorrect COPT codes; attached you will find corrected claim along with the medical records, itemized statement and EOB for your review,"

Amount in Dispute: $213.48

Respondent's Position

CorVel will maintain the requestor, Doctors Hospital at Renaissance is not entitled to reimbursement for date of service 06/25/21 in the amount of $241.64 based on incorrect coding per CMS guidelines. CorVel further notes the requestor has failed to submit a medical bill to the insurance carrier for the HCPCS code G0463 listed on the DWC 60 prior to submission of the request for medical fee dispute.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.403 sets out the billing requirements of services rendered in outpatient facility.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 234 – This procedure is not paid separately
- R5 – Not paid under OPPS

Issues

1. Is the insurance carrier's denial based on incorrect coding supported?

Findings

1. The requestor is seeking reimbursement of services rendered in an outpatient hospital on June 25, 2021. The requestor denied the charge as being bundled and not paid under OPPS.

   DWC Rule §134.403 (d) states in pertinent part, "For coding, billing reporting and reimbursement of health care, Texas worker's compensation system participants shall apply Medicare payment policies in effect on the date a service is provided."

   Review of submitted documentation indicates original submission of claim was for code 99213. This code is not valid for services rendered in outpatient hospital setting.

   The DWC 060 indicates code G0463. DWC Rule §133.307 (c) (2) (J) states in pertinent part a the request for medical free dispute shall include a copy of all medical bills related to the dispute as originally submitted to the insurance carrier. The submitted documentation did not contain a medical bill for code G0463.

   Payment for the code listed on the DWC060, G0463, cannot be recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 21, 2021 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.