

September 22, 2023	0636	Left blank	\$0.00
September 22, 2023	0636	Left blank	\$0.00
September 22, 2023	0636	Left blank	\$0.00
September 22, 2023	0710	Left blank	\$0.00
September 22, 2023	0730	Left blank	\$0.00
Total			\$1,369.62

Requestor's Position

“Attached is a copy of an EOB, UB04, and an itemized statement, and medical records. The claim referenced below was billed with CPT Code 22852, and the Medicare reimbursement is \$1,369.62 as referenced in the copy of the Medicare Pricer included in this request.”

Amount in Dispute: \$1,369.62

Respondent's Position

“The provider has been paid all that the provider is entitled to. The payment amount is based upon the July 2023 OPSS Addendum B. There is no listed value/rate for that code. The provider is not entitled to any additional monies.”

Response submitted by: Flahive, Ogden & Latson

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 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.403](#) sets out the fee guidelines for outpatient hospital services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 5 – The procedure code/type of bill is inconsistent with the place of service.
- 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.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What service is in dispute?
2. What rule is applicable to reimbursement?

Findings

1. The DWC 60 indicates revenue codes and an amount in dispute listed under 370 – Anesthesia however in their position statement the requestor states, "The claim referenced below was billed with CPT Code 22852..." Based on this position statement Code 22852 is reviewed below.
2. DWC 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 are found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

A review of the applicable Addendum B at www.cms.gov, finds the status indicator for Code 22852 is "C" which is defined as "Inpatient Procedures," "Not paid under OPPS. Admit patient. Bill as inpatient." Based on this review, no payment is 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 entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April 12, 2024
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, 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 electrónico CompConnection@tdi.texas.gov.