TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Surgical Hospital

Respondent Name
Insurance Co of the State of PA

MFDR Tracking Number
M4-24-1679-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
April 4, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 30, 2023	x9907	244.63	$0.00
October 30, 2023	x9907	13.27	$0.00
October 30, 2023	x9907	5.08	$0.00
October 30, 2023	x9907	1,150.71	$0.00
October 30, 2023	C1755	0	$0.00
October 30, 2023	C1772	0	$0.00
October 30, 2023	62362	0	$0.00
October 30, 2023	X9907	904.00	$0.00
	Total	2,317.69	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration dated March 26, 2024 that states, "According to TX Workers Compensation Fee Schedule the expected reimbursement for DOS 10/30/2023 is $22,428.30. Please note that carriers to pay either fee schedule; or billed charges. Previous payment received totaled $20,110.61. Please reprocess and remit payment for remaining balance due."

Amount in Dispute: $2,317.69

Respondent's Position

"The provider's DWC 60 packet included two EOBs dated December 30, 2023 and March 17, 2024. Those EOBs recommended payment of $20,110.61. The provider's request for reconsideration fails to explain why the carrier should modify its previous decision. The carrier's position remains as stated in its EOBs."

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 billing procedures for outpatient hospital claims.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- TX618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- P13 – Payment reduced or denied based on workers compensation jurisdictional regulations or payment policies.
- XXU03 – The billed service was reviewed by UR and authorized.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What services are in dispute?

2. What rule is applicable to reimbursement?

Findings

1. The requestor listed the following on the DWC60 showing amounts in dispute at the time of their request for MFDR.

    - x9907 - $244.63
    - x9907 - $13.27
    - x9907 - $5.08
    - x9907 - $1,150.71
    - x9907 - $904.00

    Review of the submitted medical bill found the following descriptions of the amounts shown above.

    - Revenue Code 250 – Pharmacy General Classification, $244.63
    - Revenue Code 258 – Pharmacy IV Solutions, $13.27
    - Revenue Code 259 – Pharmacy Other, $5.08
    - Revenue Code 272 - Supplies & Devices Sterile, $1150.71
    - Revenue Code 710 – Recovery Room General, $904.00

    DWC Rule 28 TAC §134.403(d) states in pertinent part, "For coding, billing reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided…"

    The CMS Claims Processing Manual, Chapter 4, Section 10.4 at www.cms.gov, states,
    10.4 – Packaging -Under the OPPS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPPS. No separate payment is made for packaged services, because the cost of these items and services is included in the APC payment for the service of which they are an integral part. For example, ***routine supplies, anesthesia, recovery room use, and most drugs are considered to be an integral part of a surgical procedure so payment for these items is packaged into the APC payment for the surgical procedure.***

The insurance carrier denied these revenue codes on the submitted explanation of benefits based on packaging. Per the Medicare payment policy detailed above the insurance carrier's denial is supported, 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 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	May 2, 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, 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.