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
Texas Health Fort Worth

Respondent Name
Service American Indemnity Co

MFDR Tracking Number
M4-24-1895-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
April 19, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 11, 2024	0320	Left blank	$0.00
January 11, 2024	0450	$727.34	$0.00
January 11, 2024	0450	Left blank	$0.00
January 11, 2024	0636	Left blank	$0.00
January 11, 2024	0681	Left blank	$0.00
	Total	$727.54	$0.00

Requestor's Position

"We are in receipt of a payment of $527.88, however this claim was underpaid by $727.54. Our calculations are based on the Medicare outpatient rates for CPT code 12032 AND 99283, which is $625.61 and the outpatient work comp multiplier is 200% without separate implant reimbursement per rule 134.403… and the total work comp fee schedule allowance is $1255.42, and finally, deducting the payment $527.88, **leaves and unpaid balance due of $727.54**."

Amount in Dispute: $727.54

Respondent's Position

"This request will be standing on the fee schedule allowance of $527.88, paid correctly. Rev450/12002 has a status indicator Q APC indicator is packaged into other APC codes that have

been identified by CMS. Therefore, is not payable."

Response submitted by: Mitchell International, Inc

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.

- 16 – Claim/service lacks information or has submission/billing error(s).
- 241 – Not documented.
- 350 Bill has been identified as a request for reconsideration or appeal.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 371 – This hospital outpatient allowance was calculated according to the OPPS payment for this service.
- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 790 – This charge was reimbursed in accordance to the Texas medical fee guideline.
- 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 TDEWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What is the rule applicable to reimbursement?

Findings

1. The requestor is seeking payment of code 12032 – Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (**excluding hands and feet**) billed under revenue code 450 for date of service January 11, 2024. The insurance carrier denied the payment stating the procedure was not documented.

   Review of the submitted medical record found "Laceration repair of the (redacted)."

   The procedure in dispute is for a finger which is part of the hand. This procedure is excluded from Code 12032.

   Based on this review, the insurance carrier's denial is supported. No payment is recommended for code 12032.

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 additional reimbursement for the disputed services.

Authorized Signature

		May 28, 2024
Signature	Medical Fee Dispute Resolution Officer	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.