



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Trans Oakley LLC

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-24-1924-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

May 1, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 26, 2023	A4670	\$91.80	0.00
June 26, 2023	A4927	\$36.55	0.00
June 26, 2023	A4223	\$327.25	0.00
June 26, 2023	S1015	\$51.00	0.00
June 26, 2023	A4216	\$71.40	0.00
June 26, 2023	A4657	\$591.60	0.00
June 26, 2023	A6203	\$181.05	0.00
June 26, 2023	A6454	\$20.40	0.00
June 26, 2023	A4770	\$638.35	0.00
June 26, 2023	J2550	\$45.05	0.00
June 26, 2023	J7030	\$125.80	0.00
June 26, 2023	E1399	\$17.00	0.00
June 26, 2023	94761	\$636.55	0.00
June 26, 2023	29584	\$512.55	0.00
June 26, 2023	36415	\$67.15	0.00
June 26, 2023	96523	\$535.50	0.00
June 26, 2023	96365	\$2,816.90	0.00
June 26, 2023	96366	\$1,161.95	0.00
June 26, 2023	85025	\$274.55	0.00
June 26, 2023	80053	\$753.10	0.00
June 26, 2023	85379	\$629.00	0.00

June 26, 2023	84484	\$539.75	0.00
June 26, 2023	82553	\$692.75	0.00
June 26, 2023	83874	\$520.20	0.00
June 26, 2023	81003	\$204.85	0.00
June 26, 2023	80305	\$753.95	0.00
June 26, 2023	93005	\$1,105.00	0.00
June 26, 2023	99284	\$5,417.00	0.00
June 26, 2023	A4305	\$63.75	0.00
Total		\$18,882.75	\$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a copy of their reconsideration that states, "Please review this claim for consideration of payment. TotalCare's doctors and staff took great care of your member in a state of medical emergency."

Amount in Dispute: \$18,882.75

Respondent's Position

"Texas Mutual has reviewed the DWC-60 submitted by TRANS OAKLEY LLC. Texas Mutual issued payment for this date of service in the amount of \$1,024.87. Our position that no additional payment is due."

Response submitted by: Texas Mutual

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 hospital facility outpatient fee guideline.
3. [28 TAC §133.10](#) sets out the billing requirements of outpatient hospital claims.

Denial Reasons

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

- CAC-B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.

- CAC-P12 – Workers’ Compensation jurisdictional fee schedule adjustment.
- CAC-181 – Procedure code was invalid on the date of service.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC-236 – This billing code is not compatible with another billing code provided on the same day according to NCCI or workers’ compensation state regulations/fee schedule requirements.
- CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- DC4 – No additional reimbursement allowed after reconsideration. For information call (888) 532-5246.
- 350 – In accordance with TDI-DWC Rule 134.804, this 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.
- 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.
- 446 – This add-on code has been denied as the principal procedure was not billed.
- 612 – No payment is made as Medicare uses another code for reporting and/or payment of this service, submit corrections w/l 95 days from DOS.
- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- 617 – This item or service is not covered or payable under the Medicare Outpatient Fee Schedule.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 714 – Accurate license, CPT/HCPCS, NDC 3, dates, units, days supply, modifiers are required. Submit corrections w/l 95 days from DOS.
- 746 – Routine labs (drug/alcohol, etc.) test for employer & as part of employer policy are not reimbursable by the carrier.
- 767 – Paid per O/P fg at 200%: Implants not applicable or separate reimbursement (with cert) not requested per Rule 134.403(G).

Issues

1. Is the bill type 131 supported?

Findings

1. The requestor is seeking additional payment for services submitted on UB04- CMS1450 as bill type 131. The insurance carrier made a payment based on workers’ compensation fee schedule and Medicare OPPS.

Bill type 131 is defined as.

- 1 = Hospital
- 3 = Outpatient
- 1 = Admit thru discharge (total course of treatment)

DWC Rule 28 TAC §134.403 (a)(1) states in pertinent parts, “This section applies to medical services provided in an outpatient acute care hospital.”

DWC Rule 28 TAC §134.403 (b) (1) defines “Acute care hospital” as a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma.

A review of the submitted medical bill found the National Provider Identifier (NPPES) is 1417615006. This NPI indicates a primary taxonomy of 261QE002X – Clinic/Center – Emergency care.

The Division finds Trans Oakley LLC does not meet the definition of Acute Care Hospital.

DWC Rule 28 TAC §133.10 (2) states in pertinent part, “The following data content or data elements are required for a complete institutional medical bill...”

As stated above the NPI number associated with the requestor is for Clinic/Emergency Care.

The submitted bill type (131) is not supported as billed. No payment is recommended.

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

June 17, 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 electrónico CompConnection@tdi.texas.gov.