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 Orthopedic & Spine Hospital

**Respondent Name**
Texas Mutual Insurance Co.

**MFDR Tracking Number**
M4-25-1119-01

**Carrier's Austin Representative**
Box Number 54

**DWC Date Received**
January 24, 2025

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| July 23, 2024 | C1713 | $4,133.80 | $0.00 |
| July 23, 2024 | 27513 | $16,076.00 | $0.00 |
| | **Total:** | $20,209.80 | $0.00 |

## Requestor's Position

"Per EOB received CPT code 27513 was denied payment due to allowance for this inpatient service is not appropriate when supplied in an outpatient setting. Please note that authorization was approved for outpatient services and proof of authorization enclosed for review."

**Amount in Dispute:** $20,209.80

## Respondent's Position

"Per OPPS Addendum B CFT code 27513 has a status 'C' indicator, which signifies that the procedure is an 'inpatient only' procedure, meaning it is not payable under the Outpatient Prospective Payment System (OPPS) and should be billed as an inpatient service, and service cannot be paid for if performed in an outpatient setting. Addendum D1 indicates the procedure is not paid under OPPS, bill as inpatient. The facility billed for outpatient services. Texas Mutual reviewed the bill in accordance with Rule 134.403 - Hospital Facility Fee Guideline Outpatient and

OPPS/APC Medicare Fee Guideline. Further, preauthorization is not a guarantee of payment as it does not address coding and reimbursement guidelines. Our position is that no payment is due."

**Response submitted by:** Texas Mutual Insurance Co.

## 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.

Adjustment Reasons

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

- 5 – The procedure code/bill type is inconsistent with the place of service.
- 496 - ALLOWANCE FOR THIS INPATIENT SERVICE IS NOT APPROPRIATE WHEN SUPPLIED IN AN OUTPATIENT SETTING, UNLESS PRE-NEGOTIATED BY THE INSURER.
- 292 – An attachment/other documentation is required to adjudicate this claim/service.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- P12 – Workers' Compensation Jurisdictional fee schedule adjustment.
- D25 - APPROVED NON NETWORK PROVIDER FOR WORKWELL, TX NETWORK CLAIMANT PER RULE 1305.153 (C).
- 253 - IN ORDER TO REVIEW THIS CHARGE PLEASE SUBMIT A COPY OF THE CERTIFIED INVOICE.
- 618 - THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION.
- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS AREQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. What rule applies to the billing and reimbursement of the services in dispute?
2. Does preauthorization qualify the inpatient only disputed services for reimbursement in this

case?

3. Is the insurance carrier's denial reason(s) supported?
4. Is the requester entitled to reimbursement for disputed procedure code 27513?
5. Is the requester entitled to reimbursement for disputed procedure code C1713?

Findings

1. This medical fee dispute involves non-payment for outpatient facility charges rendered on July 23, 2024.

   DWC finds that Rule 28 TAC §134.403 applies to the billing and reimbursement of the services involved in this dispute. 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 is found at www.cms.gov, Claims Processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

2. A review of the submitted documentation finds a utilization review (UR) document authorizing the disputed services to be performed in an outpatient setting.

   In its position statement and request for reconsideration, the requestor argues that because the inpatient only procedure was preauthorized for an outpatient setting, the service should receive reimbursement per Texas Workers' Compensation guidelines.

   A review of CMS Outpatient Prospective Payment System (OPPS) Addendum B finds that disputed procedure code 27513 has a payment status indicator of "C" which indicates the procedure is inpatient only and not payable when performed in an outpatient setting. Therefore, 28 Texas Administrative Code Rule §134.403 applies, which states in pertinent part,

   > "(i) Notwithstanding Medicare payment policies, whenever Medicare requires a specific setting for a service, that restriction shall apply, unless an alternative setting and payment has been approved through the Division's preauthorization, concurrent review, or voluntary certification of health care process.
   >
   > "(j) A preauthorization request may be submitted for an alternative facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request. Copies of the agreement shall be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1).
   >
   > > "(1) The agreement between the insurance carrier and the party that requested the alternative facility setting must be in writing, in clearly stated terms, and include:
   > >
   > > (A) the reimbursement amount;
   > > (B) a description of the services to be performed under the agreement;
   > > (C) any other provisions of the agreement; and

(D) names of the entities, titles, and signatures of both parties, and names, titles, signatures with dates of the persons signing the agreement."

A review of the submitted documents finds that the requestor did not submit any evidence that an agreement was reached prior or during preauthorization. The dispute packet did not contain a signed copy of an agreement, that identified the parties to the agreement, or the amount of reimbursement as required by 28 Texas Administrative Code §134.403(i)-(j). As a result, DWC finds that preauthorization in this case does not qualify the disputed inpatient only procedure 27513 for reimbursement in an outpatient setting.

3. Per the explanation of benefits submitted, the insurance carrier denied payment for the services in dispute based on procedure code billed was inconsistent with the place of service and/or the inpatient service is not allowed payment when supplied in an outpatient setting.

   Per review of the documents submitted, DWC finds that the services in dispute were billed on a UB-04 institutional medical bill form with field 4, type of bill, populated with bill type code 131, which indicates "Hospital Outpatient admit through discharge."

   The primary surgical service in dispute was billed under procedure code 27513, which is described as "open reduction and internal fixation of a femoral fracture that may require the use of hardware such as plates, screws, or nails for stabilization."

   A review of the CMS Outpatient Prospective Payment System (OPPS) Addendum B finds that procedure code 27513 is assigned a payment status indicator of "C". Status indicator "C" indicates an inpatient only procedure, which is not paid under OPPS and is not assigned an APC code. Therefore, DWC finds that procedure code 27513 is not payable when performed or billed as an outpatient procedure, in accordance with Medicare payment policies.

   DWC finds that the insurance carrier's reason for denial is supported.

4. The requestor is seeking reimbursement in the amount of $16,076.00 for procedure code 27513 rendered on July 23, 2024. Because the insurance carrier's reason for denial of procedure code 27513 is supported, DWC finds that the requestor is not entitled to reimbursement.

5. The requestor is seeking reimbursement in the amount of $4,133.80 for surgical implantable products billed under procedure code C1713. The implantable products in dispute were provided under the denied surgical procedure code 27513. For reasons discussed above, the insurance carrier's denial of surgical procedure code 27513 is supported, therefore, no reimbursement for surgical implantables can be recommended.

   DWC finds that the requestor is not entitled to reimbursement for the disputed procedure code C1713 provided on July 23, 2024.

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 that the requestor 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 4, 2025<br>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.