



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Texas Spine and Joint Hospital

Respondent Name

Utica Mutual Insurance Co

MFDR Tracking Number

M4-25-1471-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

March 4, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 13, 2024	Rev 0250	\$25.95	\$0.00
August 13, 2024	Rev 0255	\$94.85	\$0.00
August 13, 2024	Rev 0258	\$13.80	\$0.00
August 13, 2024	Rev 0270	\$24.00	\$0.00
August 13, 2024	CPT 64483 RT KX	\$3420.00	\$1,607.46
August 13, 2024	Rev 0370	\$4659.00	\$0.00
August 13, 2024	Rev 0710	\$450.00	\$0.00
Total		\$8,687.60	\$1,607.46

Requestor's Position

"It is the Hospital's position that it provided all necessary documents in order to process the claim for payment. Further, the denials by Utica National Insurance/Genex are inadequate and do not provide enough information for the Hospital to provide the information necessary in order to have the claim paid. Finally, the denials do not address any indication that the main or principal procedure is preventing denial of the claim."

Amount in Dispute: \$8,687.60

Respondent's Position

The Austin carrier representative for Utica Mutual Insurance Co is Burns Anderson Jury & Brenner. The representative was notified of this medical fee dispute on March 11, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 rules and fee guidelines for outpatient hospital services.

Denial Reasons

- 251 – The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Did the respondent support the denial for lack of information?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment of outpatient hospital services rendered on August 13, 2024. The insurance carrier denied the claim originally stating lack of necessary documentation. This denial was maintained upon reconsideration. The insurance carrier did not submit a position statement in response to the request for MFDR in support of this denial.

The DWC Rules applicable to Medical Bill Submission found in DWC Rule 28 TAC §133.20 (c) states "A health care provider must include correct billing codes from the applicable division fee guidelines in effect on the date or dates of service when submitting medical bills." Review of the submitted medical bill found the code submitted that corresponds to the "Pain Management Procedure Report" (64483 – Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level). The insurance carrier's denial is not supported.

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 is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

DWC Rule 28 TAC §134.403 (e)(2) states in pertinent part, regardless of billed amount, if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

DWC Rule 28 TAC §134.403 (f) states in pertinent part the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*.

The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent. Review of the submitted medical bill found a request for implants is not applicable.

The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non-labor portion determines the Medicare specific amount. Review of the submitted medical bill and the applicable fee guidelines referenced above are shown below.

- Procedure code 64483 has status indicator T. This code is assigned APC 5443. The OPPS Addendum A rate is \$868.45 multiplied by 60% for an unadjusted labor amount of \$521.07, in turn multiplied by facility wage index 0.8758 for an adjusted labor amount of \$456.35.

The non-labor portion is 40% of the APC rate, or \$347.38.

The sum of the labor and non-labor portions is \$803.73.

The Medicare facility specific amount is \$803.73 multiplied by 200% for a MAR of \$1,607.46.

3. The total recommended reimbursement for the disputed services is \$1,607.46. The insurance carrier paid \$0.00. The amount due is \$1,607.46. This amount 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 established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Utica Mutual Insurance Co must remit to Texas Spine and Joint Hospital \$1,607.46 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

May 28, 2025

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.