



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Orthopedic & Spine Hospital

Respondent Name

LM Insurance Corp

MFDR Tracking Number

M4-25-1627-01

Carrier's Austin Representative

Box Number 60

DWC Date Received

March 21, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 16, 2024	96372	\$258.53	\$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of a document titled "Reconsideration" dated March 21, 2025, that states, "Per EOB received, CPT code 96372 was not paid correctly per TX work comp fee schedule."

Amount in Dispute: \$258.53

Respondents' Position

"We have again reviewed payment for the services of April 16, 2024, and determined that reimbursement was issued according to the guidelines provided by the Texas Medical Fee Schedule. Medicare Reimbursement is \$64.63 x 200% = \$129.26. No additional payment is due."

Response submitted by: Liberty 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 the rules and fee guidelines for outpatient hospital services.

Denial Reasons

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- X596 – Claim has been re-evaluated based on additional documentation submitted. No additional payment due.

Issues

1. What is the rule applicable to reimbursement?

Findings

1. The requestor is seeking additional payment of code 96327 – Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular. The insurance carrier paid for one unit (three units were submitted on the medical bill) stating payment based on workers' compensation fee schedule. DWC Rule 134.403 (d) states in relevant parts, "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..." DWC Rule 134.403 (b)(3) defines Medicare payment policy as "Reimbursement methodologies, models and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare." Review of the NCCI edits at www.cms.gov, found code 96372 has an unbundle relationship with code 99284. The

submitted medical record and medical bill did not document a separate and distinct service. Additional payment is not 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 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

Signature

Medical Fee Dispute Resolution Officer

April 16, 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.