

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

AdventHealth

Respondent Name

Siriuspoint America Insurance

MFDR Tracking Number

M4-25-2626-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

June 23, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 5, 2024	99183	\$9,091.45	\$0.00

Requester's Position

The requester submitted a document titled "Reconsideration" dated June 12, 2025 that states, "Per the EOB the bill was denied due to 'this procedure is not paid separately.' Please be advised that this is not a bundle and other bills on this claim have been paid with CPT 99183 as the pt has been having hyperbaric oxygen therapy in treating the approved WC injury after having surgery... Please review this appeal for payment as it is separately payable."

Amount in Dispute: \$9,091.45

Respondent's Position

"The denial was due to the facility using a code that is not accepted by Medicare. While the HBO therapy code, 99183, is a valid CPT code, it is **not** valid for use by a facility. A subsequent bill was submitted by the HCP. It was received by the carrier via fax on **12/23/2024**; however, it was not identified as a reconsideration, did not contain a letter addressing the reason for resubmission, had no change in coding and did not include a copy of the original EOR. While the fax cover sheet indicates 'this is not a duplicate', there was nothing different included with the billing, it was processed as a duplicate."

Findings and Decision

Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §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 billing guidelines for outpatient hospital medical bills.

Denial Reasons

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

- 234 – This procedure is not paid separately
- RB – Not paid under OPPS; no sep payment/package svc
- 352 – Network disc not applicable to procedure billed

Issues

1. What rule is applicable to the disputed service?
2. Is the requester entitled to reimbursement?

Findings

1. The requester is seeking reimbursement of outpatient hospital services billed under code 99183 – "Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session." DWC Rule 28 TAC §134.403 (d) states, "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 is provided with any additions or exceptions specified in this section..."

DWC Rule 28 TAC §134.403 (b)(3) defines Medicare payment policy as, "Medicare payment policy" means 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.

The applicable Medicare payment policy is found in the applicable Addenda B for the date of service at www.cms.gov which indicates the following;

- 99183 – Hyperbaric oxygen therapy has a status indicator of “B”.
- Addendum D1 at www.cms.gov defines Status Indicator B as – Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type.

2. Based on this review, the insurance carrier’s denial as not paid under OPPS is upheld. No payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester 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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to \$0.00 reimbursement for the disputed services

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July 9, 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 three 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 tres o correo electronico CompConnection@tdi.texas.gov.