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
Texas Spine and Joint Hospital

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-22-0395-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
October 26, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 26 2020	0250	$5.0-0	$0.00
October 26 2020	0255	$66.65	$0.00
October 26 2020	0320	$4,808.00	$688.00
October 26 2020	03.50	$5751.00	$688.00
	Total	$10,630.55	$1,376.00

Requestor's Position

"No explanation of benefits or documentation supporting this denial was attached. ...We appeal this denial, and have not received a response."

Amount in Dispute: $10,630.55

Respondent's Position

Texas Mutual originally responded on November 9, 2021 stating request for MFDR was untimely. After notification from MFDR of the correct date the request for MFDR was received Texas Mutual stated on November 10, 2021 "they would have request for MFDR completed right away." No additional information was received.

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 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.

Denial Reasons

Neither party submitted an explanation of benefits that supports adjudication of the services in dispute.

Issues

1. What rule applies for determining reimbursement for the disputed services?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for outpatient hospital services rendered in October of 2020. 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 (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 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 is shown below.

- Procedure code 73115 has status indicator Q2 and is assigned APC 5572. The OPPS Addendum A rate is $381.85 multiplied by 60% for an unadjusted labor amount of $229.11, in turn multiplied by facility wage index 0.8348 for an adjusted labor amount of $191.26.

  The non-labor portion is 40% of the APC rate, or $152.74.

  The sum of the labor and non-labor portions is $344.00.

  The Medicare facility specific amount is $344.00 multiplied by 200% for a MAR of $688.00.

- Procedure code 25246 has status indicator N reimbursement is included with payment for the primary services.

- Procedure code 76376 has status indicator N reimbursement is included with payment for the primary services.

- Procedure code 73201 has a status indicator of Q3 for composite if OPPS criteria are met. As packaging criteria were not met, this line is separate.

  This code is assigned APC 5572. The OPPS Addendum A rate is $381.85 multiplied by 60% for an unadjusted labor amount of $229.11, in turn multiplied by facility wage index 0.8348 for an adjusted labor amount of $191.26.

  The non-labor portion is 40% of the APC rate, or $152.74.

  The sum of the labor and non-labor portions is $344.00.

  The Medicare facility specific amount is $344.00. This is multiplied by 200% for a MAR of $688.00.

2. The total recommended reimbursement for the disputed services is $1,376.00. The insurance carrier paid $0.00. The amount due is $1,376.00. 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 $1,376.00 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 Texas Mutual must remit to Texas Spine and Joint Hospital $1,376.00 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	July 5, 2022 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.