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 Surgical Hospital at Trophy Club

Respondent Name
Tarrant Co

MFDR Tracking Number
M4-22-0551-01

Carrier's Austin Representative
Box Number 43

DWC Date Received
November 16, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 28, 2020	29888	$4100.69	$4100.69
	Total	$4100.69	$4100.69

Requestor's Position

The request did not submit a position statement but submit a copy of their reconsideration that states, "According to TX workers compensation fee schedule the expected reimbursement for CPT code 29888 is $11,716.25. Please note that separate reimbursement for Rev cod 278 was not requested in Box 80 of UB-04 for implants."

Amount in Dispute: $4,100.69

Respondent's Position

The Austin carrier representative for Tarrant County is JI Specialty Services. The representative was notified of this medical fee dispute on November 23, 2021.

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 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

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

- 16 – Claim/service lacks information which is needed for adjudication
- 97 – The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated
- 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
- 226 – Information requested from the billing/rendering provider was not provided or was insufficient/oincomplete

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 additional reimbursement for outpatient hospital services rendered in Decembe 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).

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. This amount is multiplied by 200 per cent when separate reimbursement of implants is not requested.

Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

- Procedure code 29888 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure.

  This code is assigned APC 5114. The OPPS Addendum A rate is $6,264.95 multiplied by 60% for an unadjusted labor amount of $3,758.97, in turn multiplied by facility wage index 0.9608 for an adjusted labor amount of $3,611.62.

  The non-labor portion is 40% of the APC rate, or $2,505.98.

  The sum of the labor and non-labor portions is $6,117.60.

  The Medicare facility specific amount is $6,117.60 multiplied by 200% for a MAR of $12,235.20.

2. The total recommended reimbursement for the disputed services is $12,235.20. The insurance carrier paid $7,615.56. The requestor is seeking additional reimbursement of $4,100.69. 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 of $4,100.69 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 Tarrant County must remit to Baylor Surgical Hospital at Trophy Club $4,100.69 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.}

Authorized Signature

		February 28, 2022
Signature	Medical Fee Dispute Resolution Officer	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.