TDI Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Orthopedic & Spine Hospital

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-22-0556-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
November 18, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
07/21/2021	243342	$4,273.70	$4,269.78
	Total	$4,273.70	$4,269.78

Requestor's Position

The requestor did not submit a position statement but did submit a request for reconsideration that states, "Please note that separate reimbursement was not requested for implants."

Amount in Dispute: $4,273.70

Respondent's Position

The Austin carrier representative for Tezas Mutual is Texas Mutual. 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 [description].

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 16 – Claim service lacks information or has submissions error(s) which is needed for adjudication
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- D25 – Approved non network provider for Workwell, TX network claimant per Rule 13050153 (c)
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information
- 358 - This outpatient allowance was based on the Medicare's methodology (Part B) plus a markup
- 768 Reimbursed per O/P fg at 130%. Separate reimbursement for implantables (including certification) was requested per Rule 134.403(G)
- 770 – Implant provider chages denied per outpatient FG. Required certification not included per Rule 134.403(G)(1)
- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT code descriptions

Issues

1. Is the insurance carrier's reduction supported?
2. IWhat rule applies for determining reimbursement for the disputed services?

3. Is the requester entitled to additional reimbursement?

Findings

1. The insurance carrier reduced the payment based on fee guideline when separate reimbursement for implants is made. However, insufficient evidence was found to support the health care provider made a request for separate reimbursement of implants. The insurance carrier's reduction is not supported. The disputed charge will be reviewed per applicable fee guideline.
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).

   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. When separate reimbursement of implants is not requested, the Medicare facility amount is multiplied by 200%.

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

   - Procedure code 24342 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 is multiplied by 60% for an unadjusted labor amount of $3,758.97, in turn multiplied by facility wage index 0.9579 for an adjusted labor amount of $3,600.72.

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

     The sum of the labor and non-labor portions is $6,106.70.

     The Medicare facility specific amount is $6,106.70 multiplied by 200% for a MAR of $12,213.40.

2. The total recommended reimbursement for the disputed services is $12,213.40. The insurance carrier paid $7,943.62. The amount due is $4,269.78. 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 $4,269.78 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 Baylor Orthopedic and Spine Hospital $4,269.78 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	February 28, 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.