



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

BAYLOR ORTHOPEDIC & SPINE

Respondent Name

SERVICE LLOYDS INSURANCE COMPANY

MFDR Tracking Number

M4-22-1014-01

Carrier's Austin Representative

Box Number 01

DWC Date Received

January 27, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 17, 2021	25830	\$4,274.68	\$4,274.68
	Total	\$4,274.68	\$4,274.68

Requestor's Position

"According to TX workers compensation fee schedule the expected reimbursement for DOS 9/17/2021 is \$12,213.99. Previous payment received totaled \$7,938.71 leaving a balance of \$4,274.68. Please reprocess and remit payment for remaining balance due. 25830-UB TX O/P APC: 6106.70 x 200% = 12,213.39. Please review and adjust payment accordingly. Payment should be submitted to Unified Health Services..."

Amount in Dispute: \$4,274.68

Respondent's Position

"The previous review is being maintained (payment of \$7,938.71) and no additional allowance is recommended as the payment was in accordance with the DWC guidelines."

Response Submitted by: Mitchell

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 facility services.

Denial Reasons

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

- 252 – An attachment/other documentation is required to adjudicate this claim/service.
- P12 – Workers Compensation jurisdictional fee schedule adjustment.

Issues

1. Is the insurance carriers' denial supported?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor seeks additional reimbursement for outpatient facility services, rendered on September 17, 2021.

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.

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

- Procedure code 25830 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. This is multiplied by 60% for an unadjusted labor amount of \$3,758.97, multiplied by facility wage index 0.9579 for an adjusted labor 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 cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount is \$6,106.70. This is multiplied by 200% for a MAR of \$12,213.40.

The total recommended reimbursement for the disputed services is \$12,213.40. The insurance carrier paid \$7,938.41. The requestor is seeking additional reimbursement of \$4,274.68. This amount is recommended.

2. The DWC finds that the requestor is entitled to additional reimbursement in the amount of \$4,274.68.

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. The DWC finds the requester has established that additional reimbursement of \$4,274.68 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to an additional payment for the disputed services. It is ordered that the respondent must remit to the requestor \$4,274.68 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 17, 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 electrónico CompConnection@tdi.texas.gov.