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 Orthopedic & Spine Hospital

Respondent Name
Tx Assoc of Counties Risk Mgmt Pool

MFDR Tracking Number
M4-23-2058-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
April 20, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 13 – 22, 2022	23473	$293.21	$293.21
June 13 – 22, 2022	C1713	$85.90	$0.00
June 13 – 22, 2022	C1776	$6149.20	$0.00
	Total	$1135.90	$293.21

Requestor's Position

"The attached claim not paid according to the 2022 Texas work comp Fee Schedule."

Amount in Dispute: $1135.90

Respondent's Position

"As the requestor, Baylor Orthopedic & Spine Hospital has the burden to establish they are entitled to additional reimbursement. Baylor failed to provide any sufficient reasoning why they are entitled to additional reimbursement or how the limited documentation submitted justifies additional payment. As reflected in the EOBs and the letter from ForeSight, the bill review agency, TAC RMP properly reimbursed Baylor for the right shoulder surgery in accordance with Texas Workers' Compensation Act and Division Rules."

Response submitted by: Burns Anderson Jury & Brenner, LLP

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 or denied the payment for the disputed services with the following claim adjustment codes:

- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment
- 954 – The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance
- 97 – Payment adjusted because the benefit for this service is included in the payment/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
- 10 – Upon review of submitted request for reconsideration, ForeSight has determined that no additional allowance will be made
- 4 – This item was determined to be a supply/non-implantable item

Issues

1. Did the requestor submit documentation per applicable rule for implants?

2. Is the insurance carrier's reduction supported?

3. What rule is applicable to reimbursement?

4. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for implants rendered as part of an outpatient hospital surgery rendered in June of 2022. DWC Rule 28 TAC §134.403(g)(1) states in pertinent part, a facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is true and correct actual cost to the best of my knowledge." The submitted documentation did not include the required certification. No additional payment is recommended.
2. The requestor is seeking additional reimbursement for Code 23473. Review of the submitted explanation of benefits indicates the insurance carrier allowed the amount billed of $15,638.00.

   DWC Rule 28 TAC 134.403 (e) states in pertinent part, regardless of billed amount, when no specific fee schedule or contract reimbursement shall be the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

   The disputed charge will be reviewed per applicable fee guidelines.
3. 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) (1) (B) 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*. A facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement shall be multiplied by 130 percent.

   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 23473 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 5115. The OPPS Addendum A rate is $12,593.29. This is multiplied by 60% for an unadjusted labor amount of $7,555.97, in turn multiplied by facility wage index 0.9552 for an adjusted labor amount of $7,217.46.

The non-labor portion is 40% of the APC rate, or $5,037.32.

The sum of the labor and non-labor portions is $12,254.78.

The Medicare facility specific amount is $12,254.78 multiplied by 130% for a MAR of $15,931.21.

4. The total recommended reimbursement for the disputed service is 15,931.21. The insurance carrier paid $15,638.00. The amount due is $293.21. 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 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 Tx Assoc of Counties Risk Mgmt Pool must remit to Baylor Orthopedic & Spine Hospital $293.21 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	May 25, 2023 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.