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
Southeastern Freight Lines Inc

MFDR Tracking Number
M4-23-2099-01

Carrier's Austin Representative
Box Number 48

DWC Date Received
February 16, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 29, 2022	C9353	$3,056.90	$1086.72
	Total	$3,056.90	$1086.72

Requestor's Position

The requestor did not submit a position statement. They did submit a document titled "Reconsideration." Reconsiderations should be sent to the workers' compensation carrier not the Texas Department of Insurance. This document states, "According to TX workers compensation fee schedule the expected reimbursement for DOS 7/29/2022 is $6,715.80. Please …Previous payment received totaled $5,629.08."

Amount in Dispute: $3,056.90

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

Response submitted by: Gallagher Bassett

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:

- 50 – These are non-covered services because this is not deemed a medical necessity by the payer. (Not maintained)
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance is greater than providers charge.
- 5920 – Fee Schedule manually priced at billed charge.

Issues

1. What rule is applicable to the disputed services?

2. Is the requester entitled to additional reimbursement?

Findings

1. 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 (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.

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 C9353 is an implant the requestor seeks separate reimbursement. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are $2,779.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.

  "Axoguard Nerve Protector" as identified in the itemized statement and labeled on the invoice as "Protector" with a cost per unit of $2,779.00.

  The total net invoice amount (exclusive of rebates and discounts) is $2,779.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $277.90. The total recommended reimbursement amount for the implantable items is $3,056.90.

- Procedure code 29844 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 5113. The OPPS Addendum A rate is $2,892.28 multiplied by 60% for an unadjusted labor amount of $1,735.37, in turn multiplied by facility wage index 0.9552 for an adjusted labor amount of $1,657.63.

  The non-labor portion is 40% of the APC rate, or $1,156.91.

  The sum of the labor and non-labor portions is $2,814.54.

  The Medicare facility specific amount is $2,814.54 multiplied by 130% for a MAR of $3,658.90.

2. The total recommended reimbursement for the disputed services is $6,715.80. This amount was acknowledged in the requestor's letter dated February 16, 2023. The insurance carrier paid $5,629.08. The amount due is $1,086.72. 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 Southeastern Freight Lines Inc must remit to Baylor Orthopedic & Spine Hospital $1,086.72 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 19, 2023
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.