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
Old Republic Insurance Co

MFDR Tracking Number
M4-23-2116-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
April 26, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 5, 2022	C1713	$1,223.64	$0.00
August 5, 2022	C1762	$4,290.00	$0.00
	Total	$5,513.64	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" addressed to Texas Department of Insurance. Requests for reconsideration must be submitted to the worker's compensation carrier not TDI. This document states, "The charges were not paid correctly per TX work comp fee schedule. ...Please note that separate reimbursement was requested in Box 80 of the UB-04 form for implants and should be reimbursed at manual cost plus 10%."

Amount in Dispute: $5,513.64

Respondent's Position

"Our Fee schedule team reviewed the UB and in box 80 Remarks, there is a comment "Implant Reimbursement". Without the required verbiage in the certification of actual cost, it would seem

the facility isn't asking for separate reimbursement for the implants."

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:

- 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.
- 4097 – Paid per fee schedule. Adjusted because statue dictates allowance is greater than providers charge.

Issues

1. Did the requestor support the cost of implants per applicable rule?

2. Is the requester entitled to additional reimbursement?

Findings

1. The respondent states in their position statement, "Without the required verbiage in the certification of actual cost, it would seem the facility isn't asking for separate reimbursement for the implants." DWC Rule 28 TAC §134.403 (g)(1) states in pertinent part, "A facility billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge." Review of the requestor's documentation did not find the required certification. The respondent's position is supported.

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).

   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 29828 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 $6,397.05. This is multiplied by 60% for an unadjusted labor amount of $3,838.23, in turn multiplied by facility wage index 0.9552 for an adjusted labor amount of $3,666.28. The non-labor portion is 40% of the APC rate, or $2,558.82. The sum of the labor and non-labor portions is $6,225.10. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount is $6,225.10. This is multiplied by 200% for a MAR of $12,450.20.

2. The total recommended reimbursement for the disputed services is $12,450.20. The insurance carrier paid $12,450.20. Additional payment is not 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not

entitled to additional reimbursement for the disputed services.

Authorized Signature

		May 31, 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.