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
Sherwin Williams Co

MFDR Tracking Number
M4-23-2132-01

Carrier's Austin Representative
Box Number 48

DWC Date Received
May 1, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 20, 2022	29879	$5,629.07	$5,629.07
	Total	$5,629.07	$5,629.07

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. A document titled "Reconsideration" dated May 1, 2023 was included. The requests for reconsideration should be sent to the correct workers' compensation carrier not the Texas Department of Insurance. This document states, "Please note that operative report supports service being billed for Left Knee Arthroscopy."

Amount in Dispute: $5,629.07

Respondent's Position

"We have reviewed UB, Operative Report, email Notes and Patient History. And determined submitted appeal documentation does not support allowable."

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:

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- P12 – Workers compensation jurisdictional fee schedule adjustment
- 112 – Service not furnished directly to the patient and/or not documented

Issues

1. Is the insurance carrier's denial supported?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of outpatient surgical services rendered in October of 2022. The insurance carrier denied the service as not being documented,

   DWC Rule 28 TAC 134.403 (d) states in pertinent part, for coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided.

   The disputed code 29879 has a description of, "Arthroscopy, knee, surgical, abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture."

   Review of the submitted operative report found, "The arthroscope was inserted through the cannula and the joint was infiltrated with saline via a low pressure irrigation pump. …A large suprapatellar large plica band was present in the anterior knee and this was removed with the shaver. …the lateral meniscus revealed some fraying and small tears which were treated with the shaver. The changes articular cartilage in the lateral compartment revealed grade 2, 3 and

4 changes with some cartilage loss. A chondroplasty was performed. I used the Chondral pic in the deepest part of the defect for a chondroabrasion of the lateral condyle. …There was exposed subchondral bone present in the knee. Synovitis was present throughout the suprapatellar pouch, medial and lateral gutters, anterior compartment, and intercondylar notch. This was removed with the shaver."

Based on the submitted documentation, the DWC finds the insurance carrier's denial is not supported. The procedure described by Code 29789 is supported by operative report. The service in dispute will be reviewed per applicable fee guideline.

2. As stated previously, 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 29879 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 200% for a MAR of $5,629.08.

3. The total recommended reimbursement for the disputed services is $5,629.08. The insurance carrier paid $0.00. The requestor is seeking additional reimbursement of $5,629.07. 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 Sherwin Williams Co must remit to Baylor Orthopedic & Spine Hospital $5,629.07 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 26, 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.