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
Zurich American Insurance Co

MFDR Tracking Number
M4-23-2705-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
June 22, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 22, 2022	28730	$6,537.09	$5,858.65
	Total	$6537.09	$5,858.65

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. Rather they submitted a document titled "Reconsideration" addressed to Texas Department of Insurance. Requests for reconsideration must be sent to the workers' compensation carrier not TDI. This document states, "According to TX workers compensation fee schedule the expected reimbursement for CPT code 28730 is $24,509.56. Please note that separate reimbursement was not requested in Bos 80 of UB-04 for implants, and CPT code 28730 should be paid at 200% GARR."

Supplemental response August 9, 2023.

"Partial payment was received on dispute M4-23-2705-01. However, the remaining balance is still pending final review due to remaining balance $5,843.53."

Amount in Dispute: $6,537.09

Respondent's Position

"The carrier has reprocessed the provider's bill and has recommended an additional amount of $4,110. We are attaching a copy of the carrier's EOBs including the June 9, 2023 EOB the recommended the additional payment of $4, 110. However, the carrier is once again reprocessing the provider's bill and will be recommending an additional payment. We would ask that the Medical Review Division allow the carrier to reprocess the provider's bill to see if that will resolve the medical fee dispute."

Supplemental response July 18, 2023

"Carrier has previously responded to this dispute on July 11, 2023. The carrier has now issued payment to the provider to cover the additional $6,537.09 that the provider was requesting. We are attaching a copy of the payment summary that reflects that the carrier made four payments, two on June 10, 2023 and two on July 12, 2023 in the amount of $6,537.09. They represent the top four payments on the payment summary. The last two payments on the payment summary reflected the earlier payments that were acknowledged on the provider's DWC 60 in the amount of $17,972.47. The carrier has paid the provider all of the monies that the provider has requested."

Response submitted by: Flahive, Ogden & Latson

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:

- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 45 – Charge exceeds fee schedule maximum allowable or contracted/legislated fee arrangement.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Is the respondent's position supported?

2. What rule is applicable to reimbursement?

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of outpatient hospital services rendered in December of 2022. The insurance carrier initially recommended a reduction based on tax identification number. The explanation of benefits indicates charges reduced based on contracted/legislated fee and workers' compensation fee schedule.

   These reductions were not maintained. The respondent stated, "The carrier has paid the provider all the monies that the provider has requested." The information provided with this supplemental response was insufficient to support this statement. However, the requestor did acknowledge an additional payment of $693.56. This amount in addition to the amount of $17,972.47 totals $18,666.03.

   The remaining amount in dispute is $5,843.53, The disputed service will be reviewed per applicable fee guideline.

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 28730 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 multiplied by 60% for an unadjusted labor amount of $7,555.97, in turn multiplied by facility wage index 0.9562 for an adjusted labor amount of $7,225.02.

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

  The sum of the labor and non-labor portions is $12,262.34.

  The Medicare facility specific amount is $12,262.34 multiplied by 200% for a MAR of $24,524.68.

3. The total recommended reimbursement for the disputed services is $24,524.68. The insurance carrier paid $18,666.03. The amount due is $5,858.65. 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 $0.00 additional reimbursement for the disputed services. It is ordered that Zurich American Insurance Co must remit Baylor Orthopedic & Spine Hospital $5,858.65 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

	Medical Fee Dispute Resolution Officer	September 29, 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.