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 Surgical Hospital at Trophy Club

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-23-2995-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
July 28, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 22, 2023	24345	$4,499.12	$4,499.11
	Total	$4,499.12	$4,499.11

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 sent to the workers' compensation insurance carrier not TDI. This document states, "According to TX Workers Compensation fee schedule the expected reimbursement for CPT code 24345 is $12,854.61. Please note separate reimbursement was not requested for implants, and surgical code should be reimbursed at 200% GARR."

Amount in Dispute: $4,499.12

Respondent's Position

"Upon receipt of the MDR request, the bill as sent for reconsideration. The review determined that the provider is not due additional money. Attached is a copy of their EOR upholding the decision."

Response submitted by: ESIS

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:

- 252 – An attachment /other documentation is required to adjudicate this claim/service.
- 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.

Issues

1. Was a request made for separate reimbursement of implants?

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 March 22, 2023. The insurance carrier's explanation of benefits indicates an attachment/ documentation was required. Review of the medical bill found the requestor did not seek separate reimbursement for the implants utilized during this outpatient procedure. The services in dispute will be reviewed per applicable fee guideline when separate reimbursement of implants is not requested.

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. This amount is multiplied by 200%.

   Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

   - Procedure code 24345 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 $6,614.63 multiplied by 60% for an unadjusted labor amount of $3,968.78, in turn multiplied by facility wage index 0.9528 for an adjusted labor amount of $3,781.45.

     The non-labor portion is 40% of the APC rate, or $2,645.85.

     The sum of the labor and non-labor portions is $6,427.30.

     The Medicare facility specific amount is $6,427.30 multiplied by 200% for a MAR of $12,854.60.

3. The total recommended reimbursement for the disputed services is $12,854.60. The insurance carrier paid $8,355.49. The additional amount due is $4,499.11. 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 of $4,499.11 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 Indemnity Insurance Co of North America must remit to Baylor Surgical Hospital at Trophy Club $4,499.11 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		August 18, 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.