



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Orthopedic & Spine Hospital

Respondent Name

New Hampshire Insurance Co

MFDR Tracking Number

M4-24-0241-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

October 2, 2023

Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|-------------------|-------------------|-------------------|------------|
| February 21, 2023 | 29827 | \$4,508.56 | \$4,508.56 |
| | Total | \$4,508.56 | \$4,508.56 |

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 the Texas Department of Insurance that states, "The charges were not paid correctly per TX work comp fee schedule. ...separate reimbursement was not requested for implants."

Amount in Dispute: \$4,508.56

Respondent's Position

The Austin carrier representative for New Hampshire Insurance Co is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on October 10, 2023.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Response submitted by N/A

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 §133.10](#) sets out the billing requirements when requesting implant reimbursement.
3. [28 TAC §134.403](#) sets out the fee guidelines for outpatient hospital services.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- TX010 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- XXU03 – The billed service was reviewed by UR and authorized.
- 252 – An attachment /other documentation is required to adjudicate this claim/service.
- TX253 – In order to review this charge please submit a copy of the certified invoice.

Issues

1. Did the requestor seek separate reimbursement for 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 in February 2023. The insurance carrier reduced the payment as if the requestor sought separate reimbursement of the implants utilized in the procedure.

DWC Rule 28 TAC §133.10 (f)(1)(QQ) states UB-04/field 80 is required when separate reimbursement for surgically implanted devices is requested.

Review of the submitted medical bill found this field does not contain a request for implant reimbursement. 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 Procedure code 29827 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure as this is the highest ranking J1 code.

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 0.9562 for an adjusted labor amount of \$3,794.95.

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

The sum of the labor and non-labor portions is \$6,440.80.

The Medicare facility specific amount is \$6,440.80 multiplied by 200% for a MAR of \$12,881.60.

3. The total recommended reimbursement for the disputed services is \$12,881.60. The insurance carrier paid \$8,373.04. The amount due is \$4,508.56. 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 New Hampshire Insurance Co must remit to Baylor Orthopedic & Spine Hospital \$4,508.56 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

| | | |
|-----------|--|-------------------|
| _____ | _____ | December 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 electrónico CompConnection@tdi.texas.gov.