

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Baylor Orthopedic & Spine Hospital

**Respondent Name**

AIU Insurance Co

**MFDR Tracking Number**

M4-24-0254-01

**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	\$4,258.86
	Total	\$4,508.56	\$4,258.86

### 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 (TDI). Requests for reconsideration must be sent to the correct workers' compensation carrier not TDI. This document states, "The charges were not paid correctly per TX work comp fee schedule. According to TX Workers Compensation fee schedule, the expected reimbursement for CPT code 29827 is \$12,881.60 which surgical code should be reimbursed at 200% GARR. Also, separate reimbursement was not requested for implants. Previous payment received totaled \$8,622.74."

**Amount in Dispute:** \$4,508.56

### Respondent's Position

"The carrier's EOBs support the amount that the carrier has paid to the provider. Based on the medical fee guidelines, the provider is not entitled to any additional monies."

## **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 the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 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.
- 252 – An attachment/other documentation is required to adjudicate the claim/service.
- TX363 – This charge was reviewed according to the submitted invoice and documentation,

### Issues

1. What rule is applicable to reimbursement?
2. Is the requester entitled to additional reimbursement?

### Findings

1. The requestor is seeking additional payment of an outpatient surgical procedure for date of service February 21, 2023. The insurance carrier calculated and based allowable for implants and the reimbursement was reduced.

Review of the submitted medical bill found a request for separate reimbursement of implants was not made. The maximum allowable reimbursement for the disputed service when implant reimbursement is not requested is shown below.

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](http://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 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 with the highest ranking of submitted codes with J1 status indicators.

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% equals a total MAR of \$12,881.60.

3. The total recommended reimbursement for the disputed services is \$12,881.60. The insurance carrier paid \$8,622.74. The amount due is \$4,258.86. 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 AIU Insurance Co must remit to Baylor Orthopedic & Spine Hospital \$4,258.86 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### Authorized Signature

_____	_____	November 2, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).