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
Texas Mutual Insurance Co

MFDR Tracking Number
M4-24-0286-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
October 2, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 12, 2023	25609	$508.65	$304.72
	Total	$508.65	$304.72

Requestor's Position

The requestor did not submit a position statement with this request for Medical Fee Dispute Resolution (MFDR) but did submit a copy of their reconsideration that states, "According to TX Workers Compensation Fee Schedule the expected reimbursement for CPT code 25609 is $12,881.60. Please note surgical code should be reimbursed at 200% GARR. Previous payment received totaled $12,372.95."

Supplemental correspondence November 14, 2023.

"Carrier paid an additional payment of $203.93 for MDR# M4-24-0286-01, and provider still owed $304.72. Please provide final determination letter."

Amount in Dispute: $508.65

Respondent's Position

"To resolve this fee reimbursement dispute, Texas Mutual has elected to reprocess the disputed services in accordance with the appropriate Medical Fee Guidelines as defined per Texas Administrative Code Rule 134 – Guidelines for Medical Services, Charges and Payments."

Response submitted by Texas Mutual

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:

- 18 - Duplicate claim/service.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- D25 – Approved non network provider for Workwell, TX network claimant per Rule 1305.053 (c).
- 217 – The value of this procedure is included in the value of another procedure performed on this date.
- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation.
- 356 – This outpatient allowance was based on the Medicare's methodology (Part B) plus the Texas markup.

  787 – Paid per O/P FG at 200%: implants not applicable or separate reimbursement (with cert) not requested per rule 134.403(G).

  W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What rule is applicable to reimbursement?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment outpatient hospital services rendered in May of 2023. The insurance carrier made two payments totaling $12,576.88. The charges were reduced based on the division of workers' compensation fee schedule. The requestor wished to continue with MFDR after additional payment was made.

   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 25609 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 0.9562 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.

2. The total recommended reimbursement for the disputed services is $12,881.60. The insurance carrier paid $12,576.88. The amount due is $304.72. 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 Texas Mutual must remit to Baylor Orthopedic & Spine Hospital $304.72 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		December 8, 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.