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
M4-24-0403-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
October 16, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 9, 2023	25525	$12,528.75	$0.00
	Total	$12,528.75	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" dated September 22, 2023 addressed to the Texas Department of Insurance that states, "According to TX Workers Compensation fee schedule the expected reimbursement for CPT code 25525 is $25,410.35. Please note that CPT code 25525 should be reimbursed at 200% GARR."

Amount in Dispute: $12,528.75

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 Guideline as defined per Texas Administrative Code Rule 134 – Guidelines for Medical Services, Charges and Payments. Per APC/OPPS guidelines, the APC geographically adjusted payment rate for CPT code 25525 under

wage index 0.9562 is $6,544.61 multiplied by 200% is $13,089.22. We agree to pay the additional $207.62."

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:

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 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.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 767 – Paid per O/P FG at 200%; Implants not applicable or separate reimbursement (with cert) not requested per Rule 134.403(G).

- D25 – Approved non network provider for Workwell, Tx network claimant per rule 1305.153(C).
- 131 – Claim specific negotiated discount.
- DC3 – Additional reimbursement allowed after reconsideration.
- 920 – Reimbursement is being allowed based upon a dispute.

Issues

1. What rule is applicable to reimbursement?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of code 25525 for date of service May 9, 2023 rendered during a Workwell, Tx approved outpatient procedure. The insurance carrier made a payment of $12,881.60 on July 5, 2023 and $212.45 (included $4.83 interest) on November 6, 2023. The requestor wished to continue with the dispute after the 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, Medicare Claims Processing Manual, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), 10.4 – Packaging, C. Packaging Types Under the OPPS 6.

   J1 services are assigned to comprehensive APCs. Payment for all adjunctive services reported on the same claim as a J1 service is ***packaged into payment for the primary J1 service****.*

   Review of the submitted medical bill found two codes (Code 25525 and 25609) are classified as J1 comprehensive services.

   Review of applicable Addenda J at www.cms.gov found the **ranking** assigned to these codes are as follows.

   - Code 25525 has a ranking of 548.
   - Code 25609 has a ranking of 498. This code is the highest ranking J1 code and would be considered primary.

   Based on the above, no payment can be recommended for the disputed code 25525.

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 not 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.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 10, 2024 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.