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

Respondent Name
Allmerica Financial Benefit Insurance Co

MFDR Tracking Number
M4-24-0713-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
November 27, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 26, 2023	29827	$2,305.10	$2,305.10
	Total	$2,305.10	$2,305.10

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a copy of a document titled "Reconsideration" dated November 17, 2023 that states, "Per EOB received CPT code 29827 was not paid correctly per TX work comp fee schedule. Please note that surgical code should be reimbursed at 130% GARR, and the expected reimbursement for CPT code 29827 is $8,373.04."

Amount in Dispute: $2,305.10

Respondent's Position

"Carrier is standing by the reductions made by its bill review service as it believes those reductions to be proper."

Response submitted by The Silvera Firm

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:

- 252 – An attachment/other documentation is required to adjudicate this claim/service.
- 97 – The benefit for this service is included in the payment/allowance for another service/allowance for another service/procedure that has already been adjudicated.
- W3 – Additional payment made on appeal/reconsideration.
- J8 (P12) – The allowance for the device intensive procedure was paid at an adjusted rate.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- PS (P12) – The charge exceeds the APC rate for this service.

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 a surgical procedure rendered in an outpatient hospital setting in January of 2023. The insurance carrier indicated on their explanation of benefits and position statement a reduction was made based on "J8 – The allowance for the device intensive procedure was paid at an adjusted rate" and the workers' compensation fee schedule. Review of the disputed service based on applicable DWC and Medicare payment policies is found below.

   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 29827 has status indicator J1, for procedures paid at a comprehensive rate. The insurance carrier's reduction based on J8, device intensive is not supported.

  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 130% for a MAR of $8,373.04.

2. The total recommended reimbursement for the disputed services is $8,373.04. The insurance carrier paid $6,067.94. The amount due is $2,305.10. 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 Allmerica Financial Benefit Insurance Co must remit to Baylor Surgical Hospital $2,305.10 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 2, 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.