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 at Trophy Club

**Respondent Name**
Technology Insurance Company Inc

**MFDR Tracking Number**
M4-24-0717-01

**Carrier's Austin Representative**
Box Number 17

**DWC Date Received**
November 27, 2023

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| June 27, 2023 | 29806 | $12,502.51 | $12,502.51 |
| | **Total** | $12,502.51 | $12,502.51 |

## Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of a document titled "Reconsideration" addressed to Texas Department of Insurance dated November 9, 2023 that states, "Per EOB received CPT code 29806 was not paid correctly per TX workcomp fee schedule. According to TX workers compensation fee schedule the expected reimbursement for CPT code 29806 is $25,357.12 which should be reimbursed at 200% GARR."

**Amount in Dispute:** $12,502.51

## Respondent's Position

The Austin carrier representative for Technology Insurance Company Inc is Downs Stanford PC. The representative was notified of this medical fee dispute on December 5, 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 Texas Administrative Code (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

- 252 – An attachment/other documentation is required to adjudicate this claim/service
- 253 – In order to review this charge please submit a copy of the certified invoice.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 618 – The value of this procedure is packaged into the payment of other service performed on the same date of service.
- 648 – This service is packaged with another service performed on the same date. Payment is based on a single complexity adjusted APC rate.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- M127 – Missing patient medical record for this service.
- MA27 – Missing/Incomplete/Invalid entitlement number or name shown on the claim.
- MA30 – Missing/incomplete/invalid type of bill.
- N130 – Consult plan benefit documents/guidelines for information about restrictions for this device.
- N179 – Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
- N45 – Payment based on authorized amount.

- P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
- P13 – Payment reduced or denied based on Workers' Compensation Jurisdictional Regulations or payment policies.
- U03 – The billed service was reviewed by UR and authorized.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Did the health care provider seek separate reimbursement of the implants?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment of surgical procedures rendered in an outpatient hospital setting in June of 2023. The insurance carrier reduced the allowed amount based on workers' compensation jurisdictional fee schedule and needed to submit the certified invoice for the implants listed on the medical bill.

   DWC Rule 28 TAC §133.10 (2) (QQ) requires field 80 of the U-4 be completed when a separate request for implants is made. Review of the submitted medical bill found no request for separate implant reimbursement was made, the insurance carrier's denial is not supported. 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 codes 29806 and 29827 have status indicator J1 and this combination of surgical services qualifies for a complexity adjustment found at www.cms.gov, Addenda J. This combination is assigned APC 5115.

  The OPPS Addendum A rate is $13,048.08 multiplied by 60% for an unadjusted labor amount of $7,828.85, in turn multiplied by facility wage index 0.9528 for an adjusted labor amount of $7,459.33.

  The non-labor portion is 40% of the APC rate, or $5,219.23.

  The sum of the labor and non-labor portions is $12,678.56.

  The Medicare facility specific amount is $12,678.56 multiplied by 200% for a MAR of $25,357.12.

3. The total recommended reimbursement for the disputed services is $25,357.12. The insurance carrier paid $12,854.61. The amount due is $12,502.51. 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 Technology Insurance Company Inc must remit to Baylor Surgical Hospital at Trophy Club $12,502.51 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

| | | |
|---|---|---|
| | | February 15, 2024 |
| 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.