



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Baylor Surgical Hospital

**Respondent Name**

AIU Insurance Co

**MFDR Tracking Number**

M4-24-0878-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

December 18, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 24, 2023	28445	\$12450.20	\$0.00
August 24, 2023	28415	\$0.00	\$0.00
August 24, 2023	C1713	\$0.00	\$0.00
<b>Total</b>		\$2217.16	\$0.00

### Requestor's Position

"The attached claim not paid according to the 2023 Texas work comp Fee Schedule. We are disputing the allowed amount of the attached claim."

**Amount in Dispute:** \$2217.16

### Respondent's Position

"We are attached a copy of the provider's UB-04s and the carrier's EORs dated September 28, 2023 and November 21, 2023. Those EOBs recommended payments of \$10,215.49 and \$17.55. The provider acknowledges those payments on its DWC60. It is the carrier's position that no additional monies are owed."

**Response submitted by:** Flahive, Ogden & Latson

## 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

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P13 – Payment reduced or denied based on worker' compensation jurisdictional regulations or payment policies.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- TX618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- XXU03 – The billed service was reviewed by UR and authorized.

### Issues

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

### Findings

1. The requestor is seeking payment of surgical procedure Code 28445 – "Open treatment of talus fracture, includes internal fixation, when performed" rendered in an outpatient hospital setting on August 24, 2023. The requestor lists other codes on the submitted DWC60 but with a zero amount in dispute.

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.

Review of the CMS Medicare Claims Processing Manual, at [www.cms.gov](http://www.cms.gov) found in Chapter 4, Section 10.4 (C)(6) states, "**J1 services are assigned to comprehensive APCs. Payment for**

***all adjunctive services reported on the same claims as a J1 service is packaged into payment for the primary J1 service.***

The ranking of the J1 procedures is found in the Outpatient Hospital (OPPS) Addenda for the applicable year of service. Review of Addenda J at [www.cmw.gov](http://www.cmw.gov) for 2023 found the following information in regard to the surgery codes submitted on the medical bill.

- Code 28415 – Treat heel fracture has a status indicator of J1, APC assignment of 5114 and is ranked 419.
- Code 28445 – Treat ankle fracture has a status indicator of J1, APC assignment of 5114 and is ranked 472.

Based on this review, Code 28415 is the highest ranked J1 procedure. Any other J1 procedure (28445) is packaged into the payment of Code 28415.

Based on the applicable Medicare payment policy, the code shown on the DWC60 (28445) is not eligible for reimbursement but rather is packaged into the primary J1 procedure (28415) which is not in dispute.

**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 not entitled to additional reimbursement for the disputed services.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
January 26, 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](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).