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
Texas Health Fort Worth

Respondent Name
Amtrust Insurance Co

MFDR Tracking Number
M4-24-0920-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
December 28, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 9, 2023	0250	Left blank	$0.00
February 9, 2023	0270	Left blank	$0.00
February 9, 2023	0272	Left blank	$0.00
February 9, 2023	0272	Left blank	$0.00
February 9, 2023	0274	Left blank	$0.00
February 9, 2023	0278	Left blank	$0.00
February 9, 2023	0300	Left blank	$0.00
February 9, 2023	0300	Left blank	$0.00
February 9, 2023	0301	Left blank	$0.00
February 9, 2023	0305	Left blank	$0.00
February 9, 2023	0305	Left blank	$0.00
February 9, 2023	0309	Left blank	$0.00
February 9, 2023	0309	Left blank	$0.00
February 9, 2023	0320	Left blank	$0.00
February 9, 2023	0360	Left blank	$8,874.96
February 9, 2023	0370	Left blank	$0.00
February 9, 2023	636	Left blank	$0.00
February 9, 2023	636	Left blank	$0.00
February 9, 2023	636	Left blank	$0.00
February 9, 2023	636	Left blank	$0.00
February 9, 2023	636	Left blank	$0.00

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February 9, 2023	636	Left blank	$0.00
February 9, 2023	636	Left blank	$0.00
February 9, 2023	636	Left blank	$0.00
February 9, 2023	636	Left blank	$0.00
February 9, 2023	636	Left blank	$0.00
February 9, 2023	636	Left blank	$0.00
February 9, 2023	636	Left blank	$0.00
February 9, 2023	710	Left blank	$0.00
	Total	$8,874.96	$8,874.96

Requestor's Position

"Our calculations are based on the Medicare outpatient rates for CPT code 23615, which is $12,678.56 and the outpatient work comp multiplier is 200% without separate implant reimbursement per rule 134.403… and the total work comp fee schedule allowance is $25,357.12, and finally, deducting the payment $16,482.16, leaves an unpaid balance due of $8,874.96."

Amount in Dispute: $8,874.96

Respondent's Position

The Carrier has paid a total of $4,508.56 This amount was inclusive of the entire surgical procedure, the APC rate plus the markup. Additionally, Requestor did not provide implant invoices equal the amount they billed."

Response submitted by: Downs Stanford P.C.

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 §133.10 sets the billing requirements for medical bills.
3. 28 TAC §133.403 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.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- J49 – The allowance for this line has been summed with other allowances on the bill and re-distributed evenly.
- 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.
- N179 – Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, tis bill has been identified as a request for reconsideration or appeal.

Issues

1. Did the requestor seek separate payment for implants used during surgery?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states in their position statement, "Requestor did not provide implant invoices equal the amount they billed." DWC Rule 28 TAC §133.10 (f)(2)(QQ) states, "remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested. Review of the submitted medical bill found Box 80 is blank. Separate reimbursement of implants was not requested. The fee calculation is found below.
2. The requestor states in their position statement, "Our calculations are based on the Medicare outpatient rates for CPT code 23615…" this code is the only charge in dispute. The insurance

carrier reduced the charges based on workers' compensation fee schedule and packaging. The fee calculation of surgical procedure 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 23615 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill and listed under a Revenue Code on the DWC60 are packaged with the primary "J1" procedure.

  This code 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 $16,482.16. The amount due is $8,874.96. 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 reqeustor is entitled to additional reimbursement for the disputed services. It is ordered that Amtrust Insurance Co must remit to Texas Health Fort Worth $8,874.96 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 24, 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.