TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Orthopedic & Spine Hospital

Respondent Name
Texas Mutual Insurance Co.

MFDR Tracking Number
M4-24-0961-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
January 4, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 3, 2023	26735	$7,084.73	$0.00
	Total	$7,084.73	$0.00

Requestor's Position

"According to TX Workers Compensation fee schedule the expected reimbursement for CPT code 26735 is $12,881.60. Please note that surgical code should be reimbursed at 200% GARR. Previous payment received totaled $5,796.87. Please reprocess and remit payment for remaining balance due."

Amount in Dispute: $7,084.73

Respondent's Position

"Texas Mutual reviewed the billing and documentation and issued payment in accordance with OPPS Fee Schedule, including 200% markup which is consistent with Rule 134.403 (f)... Our position is that no payment is due."

Response submitted by: Texas Mutual Insurance Co.

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.

Adjustment Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 97 - THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- D25 - APPROVED NON-NETWORK PROVIDER FOR WORKWELL, TX NETWORK CLAIMANT PER RULE 1305.153 (C).
- 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 0/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G)
- P12 – Workers' Compensation Jurisdictional fee schedule adjustment.
- DC4 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION.

Issues

1. Did the insurance carrier reimburse the disputed service in accordance with the applicable DWC Rule 28 TAC §134.403?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking additional reimbursement in the amount of $7,084.73 for outpatient facility charges rendered on August 3, 2023. Per the explanation of benefits submitted, the insurance carrier previously issued a payment in the amount of $5,796.87 for the services 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.

   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 exists, 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 following minimal modifications shall be applied. (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

   (A) 200 percent; unless

   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent…"

   According to a review of the submitted documentation, DWC finds that the requestor did not request separate reimbursement for surgical implants. Therefore, the MAR for the disputed service shall be the Medicare facility specific reimbursement amount multiplied by 200 percent.

   DWC finds that the insurance carrier reimbursed the disputed service in accordance with DWC Rule 28 TAC §134.403.

2. The requestor is seeking additional reimbursement in the amount of $7,084.73 for outpatient surgical CPT code 26735 rendered on August 3, 2023.

   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 26735 has a status indicator J1, for outpatient comprehensive packaging.

- CPT code 26735 is the highest ranking of the J1 codes billed by the requestor on the disputed date of service and receives the comprehensive payment. Review of Addendum J for CY 2023 evaluation statistics for complexity adjustments of combinations of comprehensive HCPCS codes at www.cms.gov found the combination of J1 procedures billed on the disputed date of service does not qualify for a complexity adjustment.
- CPT code 26735 is assigned APC 5113.
- The OPPS Addendum A rate is $2,976.66 which is multiplied by 60% for an unadjusted labor amount of $1,786.00.
- The unadjusted labor amount of $1,786.00 is multiplied by the facility wage index of 0.9562 for an adjusted labor amount of $1,707.77.
- The non-labor portion is 40% of the APC rate, or $1,190.66.
- The sum of the adjusted labor amount and the non-labor portion is $2,898.43.
- Therefore, the Medicare facility specific amount is $2,898.43.
- The Medicare facility specific amount is multiplied by 200% for a MAR of $5,796.86.
- The total recommended reimbursement for the disputed services is $5,796.86.
- The insurance carrier paid $5,796.87.
- No additional reimbursement is recommended.

DWC finds that the requestor is not entitled to additional reimbursement for the disputed date of service.

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 that the requestor 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 reimbursement for the disputed services.

Authorized Signature

		February 27, 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.