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 MEDICAL CENTER

Respondent Name
STANDARD FIRE INSURANCE COMPANY

MFDR Tracking Number
M4-22-0634-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
December 2, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 4, 2021	C9352	$274.90	$0.00
	Total	$274.90	$0.00

Requestor's Position

"According to TX workers compensation fee schedule the expected reimbursement for DOS 5/4/2021 is $5,250.96. Please note that implants should be reimbursed at manual cost plus 10% which the expected reimbursement for CPT C9352 is $3,023.90. Previous payment received totaling $4,976.07 leaving a balance of $274.89. Please reprocess ad remit payment for remaining balance due." ***Amount in Dispute: $274.90***

Respondent's Position

"The Provider contends they are entitled to additional reimbursement for the disputed service. The Provider alleges that they are entitled to reimbursement at the bill charges plus 10% for the implantable used during the surgery."

Response Submitted by: Travelers

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 facility reimbursement.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 876 – Reimbursement equals the amount billed
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- W3 – No additional reimbursement allowed after review of appeal/reconsideration/ request for second review.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 876 – Reimbursement equals the amount billed

Issues

1. What rule determine reimbursement for the disputed services?
2. Is the requester entitled to additional reimbursement?

Findings

The requestor seeks reimbursement for HCPCS C9352 rendered on May 4, 2021. The insurance carrier denied/reduced the disputed services with denial reduction code(s) indicated above.

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).

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 C9352 has a status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services. As a result, the requestor is not entitled to additional reimbursement for the service 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.

The 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 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 28, 2022 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.