



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Surgical Hospital at Trophy Club

Respondent Name

New Hampshire Insurance Co

MFDR Tracking Number

M4-23-2778-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

June 29, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 26, 2022	23515	\$4,357.56	\$1,334.01
Total		\$4,357.56	\$1,334.01

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" dated June 17, 2023 that states, "According to TX workers compensation fee schedule the expected reimbursement for CPT code 2355 is \$12,450.19. Please note the surgical code should be reimbursed at 200% Medicare APC rate."

Amount in Dispute: \$4,357.56

Respondent's Position

The Austin carrier representative for New Hampshire Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on July 4, 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

Explanation of benefits with check/eft date January 19, 2023

- 95 – Plan procedures not followed.
- 97 – The benefit for this service included in the payment/allowance for another service/procedure that has already been adjudicated.
- 252 – An attachment/other documentation is required to adjudicate this claim/service.
- TX618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- TX253 – In order to review this charge please submit a copy of the certified invoice.
- TX908 – Per the CCI edits this procedure is included in the value of a comprehensive or mutually exclusive procedure billed on the same day.
- TX616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- XX000 – There was no UR procedure/treatment request received.

Explanation of benefits with check date August 2, 2023

- 97 – The benefit for this service included in the payment/allowance for another

service/procedure that has already been adjudicated.

- P12 – Workers’ compensation fee schedule adjustment.
- P13 – Payment reduced or denied based on Workers’ 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.
- TX616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- TX905 – Per the CCI edits, this procedure is included in the value of a comprehensive or mutually exclusive procedure billed on the same day.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

Issues

1. Did the respondent maintain their reduction(s)?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of surgery rendered in September of 2022 in an outpatient hospital setting. The insurance carrier originally made reductions based on UR not requested and no certified implant invoice. The reduction for the invoice was not maintained. Upon reconsideration, the insurance carrier reduced the allowed amount for the implants based on contracted/legislated fee. Insufficient evidence was found to support that a contract/fee arrangement exists between the two parties. This reduction will not be considered in this review.
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)(2) states in pertinent part, regardless of billed amount, if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable

reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables applies.

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 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. Review of the submitted medical bill found separate reimbursement of the implants was not requested. The Medicare facility specific amount will be multiplied by 200 percent.

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 23515 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure.

This code is assigned APC 5114. The OPPS Addendum A rate is \$6,397.05 multiplied by 60% for an unadjusted labor amount of \$3,838.23, in turn multiplied by facility wage index 0.9552 for an adjusted labor amount of \$3,666.28.

The non-labor portion is 40% of the APC rate, or \$2,558.82.

The sum of the labor and non-labor portions is \$6,225.10.

The Medicare facility specific amount is \$6,225.10 multiplied by 200% for a MAR of \$12,450.20.

3. The total recommended reimbursement for the disputed services is \$12,450.20. The insurance carrier paid \$8,092.63 on January 19, 2023 check 0185191688 and \$3,023.56 on August 2, 2023 via check 0190406577 for a total of \$11,116.19. The amount due is \$1,334.01. 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 New Hampshire Insurance Co must remit to Baylor Surgical Hospital at Trophy Club \$1,334.01 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

March 20, 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 electrónico CompConnection@tdi.texas.gov.