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 Orthopedic & Spine Hospital

Respondent Name
FCCI Insurance Co

MFDR Tracking Number
M4-24-0869-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
December 14, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 2, 2023	131-250	$52.61	$0.00
October 2, 2023	131-258	$11.88	$0.00
October 2, 2023	131-272	$816.86	$0.00
October 2, 2023	28485	$1,949.62	$3,149.36 ***All inclusive rate***
October 2, 2023	J0690	$11.32	$0.00
October 2, 2023	J0690	$1.57	$0.00
October 2, 2023	J1170	$3.57	$0.00
October 2, 2023	J2001	$1.68	$0.00
October 2, 2023	J2250	$2.06	$0.00
October 2, 2023	J2405	$1.05	$0.00
October 2, 2023	J2765	$1.91	$0.00
October 2, 2023	J3010	$2.77	$0.00
October 2, 2023	131-710	$292.46	$0.00
	Total	$3,149.36	$3,149.36

Requestor's Position

"According to TX Workers Compensation Fee Schedule the expected reimbursement for DOS 10/02/21023 is $12,317.40. Please note that carrier to pay either fee schedule or billed charges; not both. CPT code 28485 should be reimbursed at 200% GARR, and code was underpaid."

Amount in Dispute: $3,149.36

Respondent's Position

The Austin carrier representative for FCCI Insurance Co is Burns Anderson Jury & Brenner LP. The representative was notified of this medical fee dispute on December 19, 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

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted legislated fee arrangement.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 353 – This charge was reviewed according to the submitted invoice and documentation.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 349 – The allowance for this line has been summed with other allowance on the bill and re-distributed evenly.

Issues

1. Did the respondent support contracted/legislated fee arrangement?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The explanation of benefits includes a reduction based on contracted rate. Review of the submitted documentation found insufficient information to support a contract exists between the two parties. This reduction will not be considered in this review.
2. The requestor is seeking payment additional payment of surgical procedure in an outpatient hospital setting. The insurance carrier reduced the allowed amount based on packaging and workers compensation fee schedule.

   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 exits 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 no request for separate implant reimbursement was made. The Medicare facility specific reimbursement 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 C1713 has status indicator N reimbursement is included with payment for the primary services when no separate request for implants is made.

- Procedure code 28485 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 $6,614.63 multiplied by 60% for an unadjusted labor amount of $3,968.78, in turn multiplied by facility wage index 0.9562 for an adjusted labor amount of $3,794.95.

  The non-labor portion is 40% of the APC rate, or $2,645.85.

  The sum of the labor and non-labor portions is $6,440.80.

  The Medicare facility specific amount is $6,440.80 multiplied by 200% for a MAR of $12,881.60.

- Procedure code J0690 has status indicator N reimbursement is included with payment for the primary services.

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- Procedure code J1170 has status indicator N reimbursement is included with payment for the primary services.

- Procedure code J2001 has status indicator N reimbursement is included with payment for the primary services.

- Procedure code J2250 has status indicator N reimbursement is included with payment for the primary services.

- Procedure code J2405 has status indicator N reimbursement is included with payment for the primary services.

- Procedure code J2765 has status indicator N reimbursement is included with payment for the primary services.

- Procedure code J3010 has status indicator N reimbursement is included with payment for the primary services.

The total recommended reimbursement for the disputed services is $12,881.60. The insurance carrier paid $9,168.04. The requestor is seeking additional reimbursement of $3,149.36. 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 FCCI must remit to Baylor Orthopedic & Spine Hospital $3,149.36 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		March 14, 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.