



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Surgical Hospital

Respondent Name

Church Mutual Insurance Company

MFDR Tracking Number

M4-24-1687-01

Carrier's Austin Representative

Box Number 17

DWC Date Received

April 4, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 13, 2023	24342	\$728.17	\$728.17
Total		\$728.17	\$728.17

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of a document titled "Reconsideration" dated March 21, 2024 that states, "According to TX Workers Compensation Fee Schedule the expected reimbursement for CPT code 24342 is \$12,881.60. Please note that surgical code should be reimbursed at 200% GARR."

Amount in Dispute: \$728.17

Respondent's Position

"The Carrier has paid a total of \$12,153.43. This amount was inclusive of the entire surgical procedure, the APC rate plus the markup. In conclusion, Requestor is not owed any additional reimbursement for the surgical procedure."

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 §134.403](#) sets out the fee guidelines for outpatient hospital services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 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.
- 397 – Allowance is based on utilization review pre-authorization.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 616 – The code has a status Q APC indicator and is packaged into other APC codes that have been identified
- 618 – The value of the procedure is packaged into the payment of other services performed on the same date of service.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Worker's 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.

Issues

1. What is the rule applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of outpatient procedure code 24342 rendered July 13, 2023. The insurance carrier reduced the payment amount based on the workers' compensation fee guidelines.

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.

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 a request for implants was not 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 24342 has a status indicator of J1. 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.

2. The total recommended reimbursement for the disputed services is \$12,881.60. The insurance carrier paid \$12,153.43. The amount due is \$728.17. 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 dispute Baylor Surgical Hospital \$728.17 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

May 2, 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.