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
Charter Oak Fire Insurance Co

MFDR Tracking Number
M4-24-2365-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
June 24, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 29, 2024	C1713	$0.00	$0.00
February 20, 2024	80053	$13.20	$0.00
February 20, 2024	36415	$3.75	$0.00
February 20, 2024	83036	$12.14	$0.00
February 29, 2024	82947	$4.91	$0.00
February 20, 2024	85025	$9.71	$0.00
February 29, 2024	29827	$3,917.65	$3,536.26
	Total	$3,536.26	$3,536.26

Requestor's Position

"We are disputing the allowed amount of the attached claim. On September 1, 2008, the Texas Workers Compensation Fee Schedule and Guidelines for Hospitals drastically changed. The Fee Schedule generally allows for greater reimbursement and the **TWCC adopted Medicare/CMS Billing Guidelines and methodologies**."

Amount in Dispute: $3,536.26

Respondent's Position

"The Carrier has reviewed the documentation and contends the Provider has been reimbursed at the appropriate amount per the applicable Division-adopted fee schedule. The Carrier has reviewed the Maximum Allowable Reimbursement Calculation and contends the reimbursement is correct as calculated. The additional codes sought by the Provider are considered included in the primary procedure codes already reimbursed."

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 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.

- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 97 – Payment adjusted because the benefit for this service is included in the payment/ allowance for another service/procedure that has already been adjudicated.
- W3 – Bill is a reconsideration or appeal.
- P12 – Workers compensation jurisdictional fee schedule adjustment.
- 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.
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 170 – Reimbursement is based on the outpatient/inpatient fee schedule.

Issues

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

Findings

1. The requestor is seeking payment for outpatient hospital services rendered in February of 2024. The insurance carrier reduced the payment based on packaging and workers' compensation fee guideline.

   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, 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.

   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 implants are not applicable.

   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 (implants) is not in dispute as separate reimbursement of implants was not requested.
- Procedure code 80053 has a status indicator of Q4 and is packaged into primary procedure.
- Procedure code 36415 has a status indicator of Q4 and is packaged into primary procedure.
- Procedure code 83036 has a status indicator of Q4 and is packaged into primary procedure.
- Procedure code 82947 has a status indicator of Q4 and is packaged into primary procedure.
- Procedure code 85025 has a status indicator of Q4 and is packaged into primary procedure.
- Procedure code 29827 has a status indicator of J1. The APC associated with 29827 is 5114 with a payment rate of $6,816.33 multiplied by 60% is $4,089.80 multiplied by facility wage index of 0.9382 equals the labor adjustment amount of $3,837.05.

  The non labor rate is $2,726.53.

  The sum of the adjusted labor and nonlabor amounts is $6,563.58 multiplied by 200% equals MAR of $13,127.16.

2. The total recommended reimbursement for the disputed services is $13,127.16. The insurance carrier paid $8,957.65. The difference between the MAR amount and the insurance payment is $4,169.51. The requestor is seeking $3,536.26, 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 Charter Oak Fire Insurance Co must remit to Baylor Orthopedic & Spine Hospital $3,536.26 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	July 24, 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 electronico CompConnection@tdi.texas.gov.