TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Surgical Hospital at Trophy Club

Respondent Name
Great American Alliance Insurance Co.

MFDR Tracking Number
M4-25-0251-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 30, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 20, 2024	27130	$8,452.39	$8,452.39

Requestor's Position

"According to TX Workers Compensation Fee Schedule, surgical code 27130 should be reimbursed at 200% GARR. Per EOB received, Rev code 278 denied due to missing implant invoices. Please note that separate reimbursement was not requested in Box 80 of UB-04 for the implants… 27130-Global:UB TX O/P: Surgical @200%GARR=$24,149.69. Please review and adjust payment accordingly."

Amount in Dispute: $8,452.39

Respondent's Position

"The payment was based upon the medical fee guidelines. Any additional billing is for a procedure packaged into the payment of other services already paid. The provider is not entitled to any additional payment."

Response submitted by: Flahive, Ogden & Latson

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.

Adjustment Reasons

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

- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- U03 – The billed service was reviewed by UR and authorized.
- P12 – Workers' Compensation Jurisdictional fee schedule adjustment.
- P13 – Payment reduced or denied based on Workers' Compensation Jurisdictional regulations or payment policies.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Did the insurance carrier reimburse the disputed service in accordance with the applicable DWC Rule 28 TAC §134.403?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking additional reimbursement in the amount of $8,452.39 for outpatient facility charges rendered on March 20, 2024. The CPT code in dispute is 27130 according to the submitted Medical Fee Dispute Resolution Request form DWC060. Per the explanation of benefits (EOB) submitted, the insurance carrier previously issued a payment in the amount of $15,697.30 for the services in dispute.

   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) states in pertinent part, regardless of billed amount, when no specific fee schedule or contract exists, reimbursement shall be 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 following minimal modifications shall be applied. (1) 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…"

According to a review of the submitted documentation, DWC finds that the requestor did not request separate reimbursement for surgical implants. Therefore, the MAR for the disputed service shall be the Medicare facility specific reimbursement amount multiplied by 200 percent.

DWC finds that the insurance carrier did not reimburse the disputed service in accordance with DWC Rule 28 TAC §134.403.

2. The requestor is seeking additional reimbursement in the amount of $8,452.39 for outpatient surgical CPT code 27130 rendered on March 20, 2024.

   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 in accordance with the applicable fee guidelines referenced above is shown below.

   - Procedure code 27130 has status indicator J1, for outpatient comprehensive packaging.
   - This code is assigned APC 5115. The OPPS Addendum A rate is $12,539.82 multiplied by 60% for an unadjusted labor amount of $7,523.892, in turn multiplied by facility wage index 0.9382 for an adjusted labor amount of $7,058.915.
   - The non-labor portion is 40% of the APC rate, or $5,015.928.
   - The sum of the adjusted labor amount and the non-labor portion is $12,074.843.
   - Therefore, the Medicare facility specific amount is $12,074.843. This amount is multiplied by 200% for a MAR of $24,149.69.

- A review of the EOBs submitted finds that the insurance carrier paid $15,697.30 for the service in dispute.
- DWC finds that the requestor is entitled to additional reimbursement in the amount of $8,452.39.

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 that the requestor has established that additional reimbursement in the amount of $8,452.39 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 Great American Alliance Insurance Co. must remit to Baylor Surgical Hospital at Trophy Club $8,452.39 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	November 7, 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.