



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Baylor Orthopedic & Spine Hospital

**Respondent Name**

Pennsylvania Manufacturers Association

**MFDR Tracking Number**

M4-25-0310-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

October 7, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 14, 2024	27792	\$1,333.03	\$1,333.03
<b>Total</b>		<b>\$1,333.03</b>	<b>\$1,333.03</b>

### Requestor's Position

"According to TX Workers Compensation Fee Schedule CPT code 27792 should be reimbursed at 200% GARR. Previous payment received totaled \$11,794.13."

**Amount in Dispute:** \$1,333.03

### Respondent's Position

"The reimbursement rate depends upon whether the provider billed separately for the implant. The carrier reimbursed the provider based upon its initial bill. The provider is not entitled to any additional monies."

**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 reimbursement guidelines for outpatient hospital services.

## Denial Reasons

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 802 – Charge for this procedure exceeds the OPPTS schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 4097 – Paid per fee schedule; Charge adjusted because status dictates allowance is greater than provider's charge.
- 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.

## 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 outpatient hospital services rendered in March of 2024. The insurance carrier adjusted the payment amount based on supplier's charge.

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](http://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 is 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 are shown below.

- Procedure code 27792 has status indicator J1, for procedures paid at a comprehensive rate. This code is assigned APC 5114. The OPPS Addendum A rate is \$6,816.33 multiplied by 60% for an unadjusted labor amount of \$4,089.80, in turn multiplied by facility wage index 0.9382 for an adjusted labor amount of \$3,837.05.

The non-labor portion is 40% of the APC rate, or \$2,726.53.

The sum of the labor and non-labor portions is \$6,563.58.

The Medicare facility specific amount is \$6,563.58 multiplied by 200% for a MAR of \$13,127.16.

2. The total recommended reimbursement for the disputed services is \$13,127.16. The insurance carrier paid \$11,794.13. The amount due is \$1,333.03. 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 Pennsylvania Manufacturers Association must remit to Baylor Orthopedic & Spine Hospital \$1,333.03 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).