



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

North Central Surgical Hospital

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-25-0523-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

October 30, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 23, 2024, to February 27, 2024	C1776	\$8030.00	\$0.00
February 23, 2024, to February 27, 2024	C1713	\$3025.00	\$0.00
February 23, 2024, to February 27, 2024	81003	\$2.81	\$0.00
February 23, 2024, to February 27, 2024	85018	\$2.96	\$0.00
February 23, 2024, to February 27, 2024	36415	\$3.75	\$0.00
February 23, 2024, to February 27, 2024	83036	\$12.14	\$0.00
February 23, 2024, to February 27, 2024	80047	\$17.16	\$0.00
February 23, 2024, to February 27, 2024	82947	\$4.91	\$0.00
February 23, 2024, to February 27, 2024	82947	\$4.91	\$0.00
February 23, 2024, to February 27, 2024	85730	\$7.51	\$0.00
February 23, 2024, to February 27, 2024	85610	\$5.36	\$0.00

February 23, 2024, to February 27, 2024	23472	\$0.00	\$11,116.15
Total		\$4891.14[sic] \$11,116.15	\$11,116.15

Requestor's Position

"At this time, we are requesting that this claim paid in accordance with the 2024 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: \$4,891.14 [sic]

Respondents' Position

"Our position is that no additional payment is due."

Response submitted by: Texas Mutual

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 of outpatient hospital claims.
3. [28 TAC §133.10](#) sets out the billing requirements when requesting implant reimbursement.

Denial Reasons

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-16 – Claim/service lacks information or has submission/billing effort(s) which is needed for adjudication.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- DC4 – No additional reimbursement allowed after reconsideration.
- D25 – Approved non network provider for WORKWELL, TX network claimant per Rule 1305.153(c).

- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 768 – Reimbursed per O/P FG at 130%. Separate reimbursement for implantables (including certification) was requested per Rule 134.403(G).
- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT code descriptions/instructions.

Issues

1. Is the respondent's position statement supported?
2. Did the requestor correctly request implant reimbursement?
3. What is the rule applicable to reimbursement?
4. Is the requester entitled to additional reimbursement?

Findings

1. The respondent indicates in their position statement, "On the UB-04, there was no request for implant payment in accordance with rule 134.403, ...Texas Mutual reimbursed at 130%..."
DWC finds the requestor did not request separate reimbursement of the implants per applicable DWC Rule shown below. The respondent's position in the reduction of the payment is not supported. The facility specific amount will be determined per applicable DWC fee guideline.
2. The requestor is seeking payment of outpatient hospital service rendered in February of 2024. At the time of the original claim submission and upon reconsideration the submitted UB04 did not contain a request for implants in Box 80. DWC 28 TAC §133.10(f)(2) (QQ) states, "remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested." The medical bill with a creation dated October 22, 2024, is 95 days past from the date of service and will not be considered in this review.
The DWC finds the requestor did not meet the requirements of the applicable rule regarding the request for implant reimbursement.
3. 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. As detailed above, requirements of separate implant reimbursement were not met. The facility specific amount will be multiplied by 200%.

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 23472 has status indicator J1, for procedures paid at a comprehensive rate. This code is assigned APC 5116. The OPPS Addendum A rate is \$17,756.28 multiplied by 60% for an unadjusted labor amount of \$10,653.77, in turn multiplied by facility wage index 0.9331 for an adjusted labor amount of \$9,941.03.

The non-labor portion is 40% of the APC rate, or \$7,102.51.

The sum of the labor and non-labor portions is \$17,043.54.

The Medicare facility specific amount is \$17,043.54 multiplied by 200% for a MAR of \$34,087.08.

4. The total recommended reimbursement for the disputed services is \$34,087.08. The insurance carrier paid \$22,156.60. The requester is entitled to an additional payment of \$11,116.15. 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 Texas Mutual Insurance Co must remit to North Central Surgical Hospital \$11,116.15 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	November 19 , 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.