TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
TOPS Surgical Specialty Hospital

Respondent Name
Service Lloyds Insurance Co

MFDR Tracking Number
M4-25-0636-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
November 13, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 29, 2024	63650	$758.82	$758.82
	Total	$758.82	$758.82

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration dated November 1, 2024 that states, "Per EOB received bill was not paid correctly per TX work comp guidelines. Please note that separate reimbursement was not requested in Box 80 of UB-04 form and surgical code 63650 should be reimbursed at 200% GARR."

Amount in Dispute: $758.82

Respondent's Position

"We stand on the previous payment for DOS 07/29/2024 under Bill ID SLTX-278163, DOS 07/29/2024, Charged amount $ 19,552.00."

Response submitted by: Mitchell

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 rules and fee guidelines for outpatient hospital services.

Denial Reasons

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 351 – No additional reimbursement allowed after review of appeal/reconsideration.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts payment or contractual.
- 6118 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- P63 – Per your Coventry workers comp network. A certified TX HCN.
- U03 – The billed service was reviewed by UR and authorized.
- 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 support the injured worker is enrolled in a certified network?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced the allowed amount and indicates the explanation of benefits a contract was used. Review of information submitted with this request for MFDR, and the information known to the division did not find sufficient evidence to support that the injured worker is enrolled in a certified healthcare network. The insurance carrier's reduction is not supported. The maximum allowable reimbursement (MAR) will be calculated per the applicable fee guideline.

   The requestor is seeking additional payment of outpatient hospital services rendered in July of 2024. The applicable fee guideline is found in DWC Rule 28 TAC §134.403 (d) which 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 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 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 63650 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This

code is assigned APC 5462. The OPPS Addendum A rate is $6,516.28 multiplied by 60% for an unadjusted labor amount of $3,909.77, in turn multiplied by facility wage index 0.9817 for an adjusted labor amount of $3,838.22.

The non-labor portion is 40% of the APC rate, or $2,606.51.

The sum of the labor and non-labor portions is $6,444.73.

The Medicare facility specific amount is $6,444.73 multiplied by 200% for a MAR of $12,889.46.

The total recommended reimbursement for the disputed services is $12,889.46. The insurance carrier paid $12,130.64. The amount due is $758.82. 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 Service Lloyds Insurance Co must remit to TOPS Surgical Specialty Hospital $758.82 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	January 31, 2025 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.