



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Orthopedic & Spine Hospital

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-25-1102-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

January 24, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 1, 2024	27829	\$9,198.27	\$745.87
Total		\$9,198.27	\$745.87

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" that states, "According to TX Workers Compensation Fee Schedule the expected reimbursement for CPT code 27829 is \$24,149.69. Please note that separate reimbursement was not requested in Box 80 of the UB-04 form, and surgical code should be reimbursed at 200% GARR."

Amount in Dispute: \$9,198.27

Respondent's Position

"Texas Mutual reviewed the billing and documentation and issued payment per OPPS fee schedule, at 130% with separate reimbursement for implants as requested by the provider. Our position is that no 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 billing and reimbursement guidelines for outpatient hospital services.

Denial Reasons

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- Multiple J1 services are reported on the same claim, the single payment is based on the rate associated with the highest ranking J1 service.
- CAC – P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 618 – The value of the 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).
- 897 – Separate reimbursement for implantables made in accordance with DWC Rule 134: Subchapter (E) health facility fees
- CAC – W3 – In accordance with TDI-DWC Rule 134.804 this bill has been identified as a request for reconsideration or appeal.
- CAC – 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Was separate reimbursement of implants requested?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor states that separate reimbursement for implants was not made however, review of the submitted medical claim created January 14, 2025 indicates the following, "Bill claim at

130% with separate reimbursement for implants;" The requestors statement is not supported. The maximum allowable reimbursement will be reviewed per applicable fee guidelines when implants are requested.

2. The requestor is seeking additional payment of code 29827. 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. Review of the submitted medical bill found a request for implants was made. The Medicare facility specific reimbursement amount will be multiplied by 130 percent. The implants are not in dispute and no reimbursement calculation will be done.

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 27829 has status indicator J1 comprehensive code. The applicable Medicare payment policy allows for complexity adjustment of combinations of comprehensive HCPCS codes. Review of the applicable Addenda J at www.cms.gov found code 27829 and 27695 does qualify for this adjustment. All other covered services on the bill are packaged with the primary "J1" procedure.

This combination is assigned APC 5115. The OPPS Addendum A rate is \$12,539.82 multiplied by 60% for an unadjusted labor amount of \$7,523.89, in turn multiplied by

facility wage index 0.9382 for an adjusted labor amount of \$7,058.91.

The non-labor portion is 40% of the APC rate, or \$5,015.93.

The sum of the labor and non-labor portions is \$12,074.84.

The Medicare facility specific amount is \$12,074.84 multiplied by 130% for a MAR of \$15,697.29.

- 3. The total recommended reimbursement for the disputed services is \$15,697.29. The insurance carrier paid \$14,951.42. The amount due is \$745.87. 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 Baylor Orthopedic & Spine Hospital \$745.87 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		February 27, 2025
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 electrónico CompConnection@tdi.texas.gov.