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
Baylor Orthopedic & Spine Hospital

Respondent Name
Service Lloyds Insurance Co.

MFDR Tracking Number
M4-25-1123-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
January 24, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 18, 2024	Outpatient Hospital Services	$4,594.51	$4,594.51

Requestor's Position

"Per EOB received CPT code 29827 was not paid correctly per TX work comp fee schedule. According to TX Workers Compensation Fee Schedule surgical code 29827 should be reimbursed at 200% GARR ...

"29827-UB TX O/P: Surgical @ 200%GARR=$13,127.16"

Amount in Dispute: $4,594.51

Respondent's Position

The Austin carrier representative for Service Lloyds Insurance Co. is Downs Stanford PC. The representative was notified of this medical fee dispute on February 4, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 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.

Denial Reasons

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

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 305 – The implant is included in this billing and reimbursed at the higher percentage calculation.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.
- C03 – The billed service was reviewed by UR and authorized.

Issues

1. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient hospital services that included HCPCS codes 23430 and 29827. Per 28 TAC §134.403(d), requires Texas workers' compensation system participants to apply Medicare payment policies in effect on the date of service for coding, billing, reporting, and reimbursement.

28 TAC 134.403(e) 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 …"

According to the relevant part of 28 TAC 134.403(f), "the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount … 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*."

Per Medicare Claims Processing Manual (CPM), Chapter 4, Section 10.1.1, "an OPPS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged."

The submitted medical bill contained codes 23430 and 29827. Each code has the status indicator J1. Per Addendum D1, status indicator J1 indicates that the services are paid through a comprehensive APC under OPPS. With a few exceptions, all covered services on the claim are packaged with the primary service. Addendum J provides the ranking for primary service assignment in this case, ranking HCPCS code 23430 at 482 and 29827 at 515. Code 23430 is the primary code. Therefore, all covered services on the bill are packaged with code 23430.

Medicare CPM, Chapter 4, Section 10.2 states, in relevant part, "Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all the services assigned to the APC." OPPS Addendum B assigns APC 5114 to the services in question. Per Addendum A, the payment rate for this group is $6,816.33.

Medicare CPM, Chapter 4, Section 10.3 provides the Medicare facility specific reimbursement amount used for the calculation of MAR and states, in relevant part, "The OPPS national unadjusted payment rates for APCs … are calculated as the products of the scaled relative weight for the APC and the OPPS conversion factor. Hospital specific payments for these APCs are derived after application of applicable adjustment factors … and the post reclassification wage index that applies to the hospital to which payment is being made." The wage index for the facility in question is 0.9382.

The Medicare facility specific amount for the date of service in question is calculated with the following formula:

- APC payment rate x 60% = labor portion.
- Labor portion x facility wage index = facility-adjusted labor portion.
- APC payment rate x 40% = non-labor portion.
- Facility-adjusted labor portion + non-labor portion = Medicare facility specific amount.

Per 28 TAC 134.403(f)(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."

The requestor is not seeking separate reimbursement for implants and no outlier payment applies to the services in question. Therefore, the Medicare facility specific amount is multiplied by 200 percent in this case. Total reimbursement for HCPCS code 23430 is calculated as follows:

- $6,816.33 x 60% = $4,089.80
- $4,089.80 x 0.9382 = $3,837.05
- $6,816.33 x 40% = $2,726.53
- $3,837.05 + $2,726.53 = $6,563.58
- $6,563.58 x 200% = $13,127.16

The total recommended reimbursement for the disputed services is $13,127.16. Per explanation of benefits dated October 2, 2024, the insurance carrier paid $8,532.65. An additional reimbursement of $4,594.51 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 of $4,594.51 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 Baylor Orthopedic & Spine Hospital $4,594.51 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	April 30, 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.