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
Memorial Hermann Surgical

Respondent Name
Safety National Insurance Co

MFDR Tracking Number
M4-25-1870-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
April 14, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 17, 2024	24586	$8,670.45	$8,225.26

Requestor's Position

The requestor submitted a document titled "Reconsideration" dated April 7, 2025 that states, "Per EOB received CPT code 24586 was not paid correctly per TX work comp fee schedule. According to TX Workers Compensation Fee Schedule the expected reimbursement for CPT code 24586 is $24,804.27..."

Amount in Dispute: $8,670.45

Respondent's Position

"This hospital outpatient allowance was calculated according the APC rate plus a markup. In conclusion, Requestor is not owed any additional reimbursement for the outpatient procedure performed on 10/07/2024."

Response submitted by: Downs Stanford, PC

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

- 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
- 28 TAC §133.10 sets out required billing forms/formats for workers' compensation services.
- 28 TAC §134.403 sets out the rules and fee guidelines for outpatient hospital services.

Denial Reasons

- 16 – Claim/service lacks information or has submission/billing error(s).
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 205 – This charge was disallowed as additional information/definition is required to clarify supply rendered.
- 252– An attachment/other documentation is required to adjudicate this claim/service.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 353 – This charge was reviewed according to the submitted invoice and documentation.
- 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.
- 618 – The value of this procedures is packaged into the payment of other services performed on the same date of service.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- Q02 – No additional allowance recommended. The documentation has been evaluated and does not support an additional allowance.
- QA4 – We are unable to complete review of implant charges. Submit the cost or invoices for each implanted item billed.
- 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 requestor make a request for separate implant reimbursement?
2. Did the respondent support a contracted fee?
3. What is the rule applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment for an outpatient hospital surgery rendered on October 17, 2024. The insurance carrier stated the claim lacks information, invoices and workers' compensation fee schedule. DWC Rule 133.10 (2) (QQ) states, "remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested." Review of the submitted medical bill found a request for separate implant reimbursement was not made. The insurance carrier's payment calculation at the lower rate is not supported. The applicable fee calculation is shown below.
2. The respondent included remark code 45 that includes a reduction based on a contracted rate. Review of the information known to the division does not support the injured worker is enrolled in a certified health network or that a contract between the two parties exists. This reduction is not allowed.
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 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 as 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. The maximum allowable reimbursement (MAR) based on the submitted medical bill and applicable fee guidelines referenced above are shown below.

- Procedure code 24586 has status indicator J1, for procedures paid at a comprehensive rate. This code is assigned APC 5115. The OPPS Addendum A rate is $12,314.76 multiplied by 60% for an unadjusted labor amount of $7,388.86, in turn multiplied by facility wage index 0.9817 for an adjusted labor amount of $7,253.64.

  The non-labor portion is 40% of the APC rate, or $4,925.90.

  The sum of the labor and non-labor portions is $12,179.54.

  The Medicare facility specific amount is $12,179.54 multiplied by 200% for a MAR of $24,359.08.

4. The total recommended reimbursement for the disputed services is $24,359.08. The insurance carrier paid $16,133.82. The amount due is $8,225.26. 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 respondent must remit to requestor $8,255.26 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	May 9, 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.