TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Orthopedic and Spine Hospital

Respondent Name
Wausau Business Insurance Co

MFDR Tracking Number
M4-17-1205-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
January 3, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Total Allowable per Medicare $3,832.72."

Amount in Dispute: $1,145.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 64721-RT was previously paid at the 200% rate per Texas Fee Schedule. This has now been adjusted down to 130% ($1,763.84). HCPCS J codes are packaged items per OPPS and were denied as Procedure code not separately payable under Medicare and/or Fee Schedule guidelines. (U634). The billed implant was originally denied as The medical efficacy of this procedure has not been established. (X667). After re-re-review, this has now been paid at billed charges."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 19,2016	Outpatient Hospital Services	$1,145.64	$188.08

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 193 – CPT or HCPC is required to determine if services are payable

- W3 – CPT or HCPC is required to determine if services
- Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered
- X667 – The medical efficacy of this procedure has not been established

Issues

1. What is the maximum allowable reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement of $1,145.64 for implantables rendered during an outpatient procedure on May 19, 2016.

   28 Texas Administrative Code §134.403 (f).

   > 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 following minimal modifications shall be applied.
   >
   > > (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.

   Review of the submitted documentation finds that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent.

   28 Texas Administrative Code §134.403(g), states,

   > Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

   Review of the submitted documentation finds the following implantables:

   - Nerve wrap 7mm x 4cm" as labeled on the invoice with a cost per unit of $1,880.80.

   The total net invoice amount (exclusive of rebates and discounts) is $1,880.80. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $188.08. The total recommended reimbursement amount for the implantable items is $2,068.88.

   Procedure code 64721. This service is classified under APC 5431, which, per OPPS Addendum A, has a payment rate of $1,392.56.
   - This amount multiplied by 60% yields an unadjusted labor-related amount of $835.54.
   - This amount multiplied by the facility's annual wage index of 0.9572 yields an adjusted labor-related amount of $799.78.
   - The non-labor related portion is 40% of the APC rate or $557.02.
   - The sum of the labor and non-labor related amounts is $1,356.80.

- The total Medicare facility specific reimbursement amount for this line is $1,356.80. This amount multiplied by 130% yields a MAR of $1,763.84.

2. The total allowable reimbursement for the services in dispute is $3,832.72. This amount less the amount previously paid by the insurance carrier of $3,644.64 leaves an amount due to the requestor of $188.08.

   This amount recommended.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $188.08, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		February 17, 2017
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 in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.