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 & Spine Hospital

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-2720-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 17, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note that separate reimbursement was requested in Box 80 for implants. Previous payment received total $7,681.35 leaving balance of $29,503.19."

Amount in Dispute: $31.933.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In order to resolve this fee reimbursement dispute Texas Mutual Insurance Company has elected to reprocess the bill per implant certification received."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 25, 2020	Outpatient Hospital Services	$31,933.01	$2,896.93

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 or denied the payment for the disputed services with the following claim adjustment codes:
    - P12 – Workers' compensation jurisdictional fee schedule adjustment
    - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information

- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- A09 – DWC Rule 134.403(B)(2) & Medicare by definition of implantables does not encompass biologicals
- 768 – Reimbursed per O/P fg at 130%. Separate reimbursement for implantables (Including certification) was requested per Rule 134.403 (G).

Issues

1. Is the insurance carrier's denial supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient hospital services rendered on February 25, 2020. The insurance carrier reduced the disputed services based on bundling and workers compensation fee schedule and denied one of the implants as the definition of implant not met.

   28 TAC 134.403 (b) (2) states in pertinent part, "Implantable" means an object or device that is surgically implanted, embedded, inserted or otherwise applied."

   Review of page four of the submitted operative report found, "I then selected a large Smith & Nephew Regeneten bioinductive implant to augment the repair. The delivery system was placed to the lateral portal and the Regeneten implant deployed over the rotator cuff repair. Medially, I utilized 5 PDS tendon anchors for fixation. Laterally, I utilized 3 bone anchors. I had nice fixation of the Regeneten implant and was pleased with the repair. That completed the arthroscopic portion of the case."

   Review of the itemized invoice showed C1781 as Implant Mesh Bioindictuve. This description was also found on the submitted manufacturers invoice. Based on this review, insufficient evidence was submitted to support the insurance carrier's denial. The allowable for the denied service is found below.

2. 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).

   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 143 percent when a separate request for implant reimbursement is not made and 108 percent when separate reimbursement for implants is made.

   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 29827 has status indicator J1 and a ranking of 378. Procedure code 23430 has a status indicator of J1 and a ranking of 396. Procedure code 29823 has a status indicator of J1 and a ranking of 1612 per Appendix J of annual OPPS updates at www.cms.gov that indicates primary assignment of comprehensive HCPCS codes.

Medicare payment policy for comprehensive APC allows payment for the highest-ranking procedure or in this case 29827. This code is assigned APC 5114. The OPPS Addendum A rate is $5,699.59, multiplied by 60% for an unadjusted labor amount of $3,419.75, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of $3,329.47.

The non-labor portion is 40% of the APC rate, or $2,279.84.

The sum of the labor and non-labor portions is $5,609.31.

The Medicare facility specific amount of $5,609.31 is multiplied by 130% for a MAR of $7,292.10.

- The total net invoice amount is $4,400.00. 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 $440.00. The total recommended reimbursement amount for the implantable items is $4,840.00.

3. The total recommended reimbursement for the disputed services is $12,132.10. The insurance carrier paid $9,235.17. The amount due is $2,896.93. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. The amount ordered is $2,896.93.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $2,896.93, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 18, 2020 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

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