TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
North Central Surgical Hospital

Respondent Name
Accident Fund National Insurance Co

MFDR Tracking Number
M4-21-0830-01

Carrier's Austin Representative
Box Number 6

MFDR Date Received
January 25, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…In accordance with the TX WC fee schedule rev code 278 for implants should be paid at manual cost + 10%."

Amount in Dispute: $8.788.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: After review, Accident Fund determined the implant for which payment was issued was underpaid by $391.69 and is processing that amount as a reconsideration and will pay it. However, Accident Fund correctly disputed payment for the second implant on the basis that no invoice was submitted initially to support payment."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 31, 2020	Outpatient Hospital Services	$8,788.52	$0.00

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:
    - 11 – The recommended allowance for the supply was based on the attached invoice
    - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

- 4915 – The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount $8,788.52 for outpatient hospital services rendered on August 31, 2020. The insurance carrier denied the payment of the implant described as "Tightrope Syndemosis XP" for lack of invoice.

   Review of the submitted documentation found no invoice supporting the cost of the implant nor did the requestor include documentation to support the required billing certification found in 28 TAC §134.403 (g) (1) which states a facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

   As the requirements of the above rule were not met additional reimbursement for the disputed implant is not recommended. The additional payment of $391.60 acknowledged as received by the requestor will be taken into consideration in the calculation of the maximum allowable reimbursement found below.

2. 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 130 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 27814 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure.
     This code is assigned APC 5114. The OPPS Addendum A rate is $5,981.95. This is multiplied by 60% for an unadjusted labor amount of $3,589.17, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $3,465.34.
     The non-labor portion is 40% of the APC rate, or $2,392.78.
     The sum of the labor and non-labor portions is $5,858.12.
     The Medicare facility specific amount is $5,858.12.
     This is multiplied by 130% for a MAR of $7,615.56.

   - The total net invoice amount of the submitted invoices (exclusive of rebates and discounts) is $2,449.00. 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 $244.90. The total recommended reimbursement amount for the implantable items is $2,693.90.

The total recommended reimbursement for the disputed services is $10,309.46. The insurance carrier paid $10,309.46. No additional payment is due.

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 not established payment is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 19, 2021 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.