TDI Division of Workers' Compensation
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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
M4-21-1927-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
June 29, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 29, 2020	C1762	$5445.00	$0.00
October 29, 2020	20900	$95.19	$95.19
	Total	$5540.19	$95.19

Requestor's Position

Requestor did not submit a position statement but rather submitted a copy of their reconsideration that states, "…In accordance with the TX WC fee schedule implants should be paid at manual cost + 10%."

Amount in Dispute: $5,540.19

Respondent's Position

Per documentation submitted the purchase order confirms the allograft is "Live Tissue Human Cartilage" this is consider a biological and not an implantable per Rule 134.403(b)(2)…it was determined that Texas Mutual paid $7681.35, payment per calculated should have been $7639.83…"

Response Submitted by: Texas Mutual

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 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.403 sets out the reimbursement 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:

- DWC Rule 134.403(B)(2) & Medicare by definition if implantables does not encompass biologicals
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 97 – The benefit for this is included in the payment/allowance for another service/procedure that has already been adjudicated
- 768 – Reimbursed per O/P FG at 130%. Separate reimbursement for implantables (including certification) was requested per rule 134.403(G)
- 790 – This charge was reimbursed in accordance to the Texas Medicare Fee Guideline.

Issues

1. Is the insurance carriers' denial supported?

2. Did the requestor support separate reimbursement of the implant?

3. What rule applies for determining reimbursement for the disputed services?

4. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount $5,540.19 for outpatient hospital services rendered on October 29, 2020. The insurance carrier denied the charge for the implantable citing DWC and Medicare definition of implantable does not encompass biologicals.

Review of the submitted documentation found insufficient evidence to support the insurance carriers' position. The disputed services will be reviewed per applicable fee guideline.

2. Review of the submitted medical bill found a request for separate payment of the implant. DWC Rule 134.403 (g)(1) state in pertinent part, "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."

   The submitted documentation did not include the required certification. The requirements for separate implant reimbursement were not met.

3. 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 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 20900 has status indicator J1 as does Procedure code 29891. The Medicare Claims Processing Manual states in pertinent part, "*When multiple J1 services are reported on the same claim, the single payment is based on the rate associated with the highest ranking J1 service.*" The ranking of Code 20900 is 426, the ranking of Code 29891 is 1,598. Code 20900 receives reimbursement.

     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 0.9707 for an adjusted labor amount of $3,484.01.

     The non-labor portion is 40% of the APC rate, or $2,392.78.

     The sum of the labor and non-labor portions is $5,876.79.

The Medicare facility specific amount is $5,876.79 by 200% for a MAR of $11,753.58.

4. The total recommended reimbursement for the disputed service 20900 is $11,753.58. The insurance carrier paid $7,681.35. The requestor is seeking additional reimbursement of $95.19 for this procedure. 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 of $95.19 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 Texas Mutual must remit to Baylor Orthopedic & Spine Hospital $95.19 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September 21, 2021
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 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.