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
Baylor Orthopedic & Spine Hospital

Respondent Name
Cincinnati Insurance Co

MFDR Tracking Number
M4-21-2410-01

Carrier's Austin Representative
Box Number 06

DWC Date Received
August 24, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 15, 2020	C1713	$8549.20	$0.00
September 15, 2020	29806	$136.72	$0.00
	Total	$8686.92	$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "According to TX workers compensation guidelines, implants should be paid at manual cost plus 10% which the expected reimbursement is $9,879.10."

Amount in Dispute: $8,686.92

Respondent's Position

With further review no additional payment appears to be due to the provider as prior payment was made accordingly per rule 134.403(1)(B). OPPS hospital outpatient payment system of the APC rate at 130% as the provider did request separate reimbursement for implants which paid correctly per above calculations.

Response Submitted by: CareWorks

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.403 sets out the fee 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:

- 97 – The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

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

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of outpatient hospital services rendered September 15, 2020. The insurance carrier states in their position statement their payment is equal to the Division fee guideline.

   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 (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*. When a provider requests separate reimbursement for implants the facility specific reimbursement will be multiplied by 130 percent.

   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 for the implants and surgical procedure is shown below.

- Procedure code 29806 has status indicator J1 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 multiplied by 130% for a MAR of $7,639.83.

DWC Rule §134.403(g) states when implantables are billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, are 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.

- "Anchor Sut 2.9mm x 12.5m" as identified in the itemized statement with a cost per unit of $400.00; no invoice supporting the cost of this item was found. No reimbursement can be recommended.
- "Anchor Sut 2.9mm x 12.5m" as identified in the itemized statement with a cost per unit of $400.00; no invoice supporting the cost of this item was found. No reimbursement can be recommended.
- "Anchor Sut 2.9mm x 12.5m" as identified in the itemized statement with a cost per unit of $400.00; no invoice supporting the cost of this item was found. No reimbursement can be recommended.
- "3.0mm bc suturetak w/sut" as identified in the itemized statement and labeled on the invoice as "3.0MM BC Suturetak w/suturetape" with a cost per unit of $340.00 at 2 units, for a total cost of $680.00.

The total net invoice amount supported by the submitted invoice is $680.00. The total add-on amount of 10% is $68.00. The total recommended reimbursement amount for the implantable items is $748.00.

The total recommended reimbursement for the disputed services is $8,387.83. The insurance carrier paid $8,969.72. Additional payment is not 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

		October 12, 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.