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
Texas Mutual Insurance Co

MFDR Tracking Number
M4-22-0141-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
September 23, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 4, 2021	C9361	$4,264.70	$4,264.70
	Total	$4,264.70	$4,264.70

Requestor's Position

The requestor did not submit a position statement but submit a copy of their reconsideration that states "…separate reimbursement was requested in Box 80 of UB-04 form for implants which should be reimbursed at manual cost plus 10%.

Amount in Dispute: $4,264.70

Respondent's Position

The nerve graft is considered a "biological" and not an implant per Rule 134.402.(b)(5).

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 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:

- A09 – DWC Rule 134.403(B)(2) & Medicare by definition of implantables does not encompass biologicals
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- D25 – Approved non network provider for Workwell, Tx network claimant per Rule 1305153 (C)
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date
- 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 carriers' denial supported?

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

3. Is the requester entitled to additional reimbursement?

Findings

1. The insurance carrier states in their position statement, "The nerve graft is considered a "biological" and not an implant per Rule 134.402(b)(5)."

   The rule that is applicable to outpatient hospital services is DWC Rule 28 TAC §134.403 (b) (2) which defines an implantable as an object or device that is surgically: (A) implanted, (B) embedded, (C) inserted, (D) or otherwise applied.

   Insufficient evidence was found to support the insurance carrier's position statement.

2. 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).

   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. The Medicare facility specific amount is multiplied by 130 percent when separate reimbursement of implants is requested.

   Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

   - "Graft Avance nerve" as identified in the itemized statement and labeled on the invoice as "Graft Avance Nerve" with a cost per unit of $3,877.00.
   - The total net invoice amount (exclusive of rebates and discounts) is $3,877.00. 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 $387.70. The total recommended reimbursement amount for the implantable items is $4,264.70.

3. The total recommended reimbursement for the disputed services is $11,544.80. The insurance carrier paid $7,223.19. The requestor is seeking additional reimbursement of $4,264.70. 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 $4,264.70 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 $4,264.70 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 8, 2021 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.