Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Surgical Hospital

Respondent Name
Hartford Casuarly Insurance Co

MFDR Tracking Number
M4-22-0755-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
November 18, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 18, 2020	L8699	$265.00	$0.00
November 18, 2020	27301	$53.00	$0.00
	Total	$318.00	$0.00

Requestor's Position

The requestor did not submit a position statement but submit a copy of their reconsideration that states, "According to TX workers compensation guidelines the expected reimbursement for DOS 11/18/2020 is $5,933.49. Please reconsider additional payment or CPT code L8699. Per TX workers compensation guidelines implants should be reimbursed at manual cost plus 10% which the expected reimbursement is $2,915.00."

Amount in Dispute: $318.00

Respondent's Position

"The original bill was processed on 1/31/21 and code 27301 was paid per the fee schedule. Code L8699 was paid per ForeSight. The bill was reprocessed on 8/23/21 and paid an additional $1990.00 for code L8699 per ForeSight."

Response submitted by: The Hartford

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 the payment for the disputed services with the following claim adjustment codes:

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 131 – Claim specific negotiated discount
- 197 – Recommended allowance based on negotiated discount/rate
- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- P12 – Workers' compensation jurisdictional feee schedule adjustment
- 4458 – Foresight * charges for surgical implants are reviewed separately by Foresight Medical
- 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 of the payment status indicator determines the service is packaged or excluded from payment.

Issues

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

Findings

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

- Procedure code 27301 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 5073. The OPPS Addendum A rate is $2,318.89 multiplied by 60% for an unadjusted labor amount of $1,391.33, in turn multiplied by facility wage index 0.9707 for an adjusted labor amount of $1,350.56.

  The non-labor portion is 40% of the APC rate, or $927.56.

  The sum of the labor and non-labor portions is $2,278.12.

  The Medicare facility specific amount is $2,278.12 multiplied by 130% for a MAR of $2,961.56. No additional payment is recommended.

  Review of the submitted explanation of benefits dated January 13, 2021 indicates a payment of $2,961.56

- The requestor is seeking additional reimbursement of Code L8699 – Prosthetic implant. DWC Rule 28 TAC §134.403 (g)(1) states in pertientn part a facility billing separately for an implantable shall include with the billing a certification that the amount billed represents the acutal cost 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 acutal cost to the best of my knowledge.” Review of the submitted documentation found no required certification. No additional payment 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 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

Signature	Medical Fee Dispute Resolution Officer	April 26, 2022 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.