TDI 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 Surgical Hospital

**Respondent Name**
Travelers Indemnity Co

**MFDR Tracking Number**
M4-22-0884-01

**Carrier's Austin Representative**
Box Number 05

**DWC Date Received**
January 13, 2022

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| 05/19/2021 | C1767 | $5964.00 | $0.00 |
| 05/19/2021 | 63650 | $1128.86 | $0.00 |
| 05/19/2021 | 250 | $59.02 | $0.00 |
| 05/19/2021 | 258 | $24.38 | $0.00 |
| 05/19/2021 | 270 | $13.70 | $0.00 |
| 05/19/2021 | 272 | $920.82 | $0.00 |
| 05/19/2021 | 259 | $8.98 | $0.00 |
| 05/19/2021 | 63650/59 | $3512.00 | $0.00 |
| 05/19/2021 | 63650 | $3512.00 | $0.00 |
| 05/19/2021 | 710 | $838.00 | $0.00 |
| | Total | $15,981.76 | $0.00 |

## Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "The charges were not paid correctly per TX workers compensation guidelines. According to EOB received Rev code 278 was denied due to missing implant invoices which are enclosed for review."

**Amount in Dispute:** $15,981.76

## Respondent's Position

As to CPT code C1767, the Provider billed and supplied documentation for a Prodigy MRI Dual Electrode System. This is a complete spinal cord stimulator kit consisting of the controller/battery pack, the programmer, the charging system, and the electrodes. As noted in the operative report, however, the decision was made to only replace the two electrodes. …the Carrier contends the Provider is entitled to reimbursement for the two electrodes actually utilized in the surgical procedure. The Carrier review records of similar procedures to determine the cost of electrodes and reimbursed the Provider the cost of the two electrodes plus 10% markup per the fee schedule. As the kit, and primarily the stimulator itself which is the costliest part in the kit, was not implanted during the procedure, the Provider is not entitled to additional reimbursement.

**Response submitted by:** Travelers

## 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 and denied the payment for the disputed services with the following claim adjustment codes:

- 863 – Reimbursement is based on the applicable reimbursement fee schedule
- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- 5458 – The medical report does not substantiate the billed charge
- 8805 – Review of the submitted documentation does not substantiate or warrant separate payment for non-implanted supplies included in the kit billed. Reimbursement was made for only the items implanted. For additional payment consideration, please re-submit with an itemization of implanted item(s) only
- W3 – Additional payment made on appeal/reconsideration
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- P18 – Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service

Issues

1. Is the insurance carrier's denial supported?
2. Did the requestor support implant cost?
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 for outpatient hospital services rendered in May 2021. The insurance carrier denied code 63685 - Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling, as not supported by the medical record. Review of the document "Procedure Note" states, "The hip pocket was opened and the whole system was removed. The IPG Abbott Rechargeable battery system was placed in a sterile container for re implantation."

   The insurance carrier's denial is supported as the unit was not replaced and had previously been inserted.

2. DWC Rule 134.403 (g) (1) states 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.

   Review of the submitted invoice shows a kit that included Neurostimlator octrode (2), Prodigy neuro stimulator, charging system Prodigy neuro stimulatory, patient programmer.

   The submitted procedure note supports only the electrodes were used. Insufficient evidence was found to support the cost of the implanted electrodes. No additional reimbursement can be recommended.

3. 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. As the requestor seeks separate reimbursement of implants, the Medicare specific amount will be multiplied by 130%.

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

- Procedure code 63650 has a status indicator of J1 for a comprehensive APC. The APC is 5462 with an Addemdum A rate of $6,295.45.

  60% of this amount is $3,77.27 multiplied by the facility wage index of 0.9579 for and adjusted labor amount of $3,618.25.

  40% of the APC rate is $2,518.18.

  Sum of the adjusted labor amount and non-labor amount is $6,136.43. This is multiplied by 130% for a MAR of $7,977.36.

- Procedure code 63650 also has a status indicator of J1. Medicare payment policy found at www.cms.gov, states 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. Only one of code 63650 is allowed. No additional payment is recommended.

4. The total recommended reimbursement for the disputed services is $7,977.36. The insurance carrier paid $20,546.14. 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**

| Signature | Medical Fee Dispute Resolution Officer | February 11, 2022<br>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.