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
Heritage Park Surgical Hospital

Respondent Name
Tx Municipal League Intergovernmental Risk Pool

MFDR Tracking Number
M4-22-1043-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 2, 2022

Summary of Findings

Dates of Service	DispuC1713ted Services	Amount in Dispute	Amount Due
June 16, 2021	C1713	$27,699.98	$0.00
June 16, 2021	23410	$662.15	$80.63

Requestor's Position

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

Amount in Dispute: $28,362.13

Respondent's Position

"...the Carrier has already made the additional payment under CPT code 23410 in the amount of $662.15. ...On September 22, 2021, the Carrier issued check number 581755 in payment of additional $662.15**.** ...With respect to CPT code C1713, the Carrier has recalculated the amount owed. The Carrier calculates that the Provider is entitled to an additional $4,957.50 (the Carrier previously reimbursed the

Provider $2,000). This would represent the total implant reimbursement which would be $6,957.70."

Response submitted by: Flahive, Ogden & Latson

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:

- 353 – This charge was reviewed per the attached invoice
- 356 – This outpatient allowance was based on the Medicare's methodology (Part B) plus the Texas markup
- 370 – This hospital outpatient allowance was calculated according to the APC reate, plus a markup
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- 618 – The value of this procedure is packaged into the payment of other services performed on the same day
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

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

2. Did the requestor support the cost of each separately requested implant?

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).

   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*.

   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 23410, billed June 16, 2021, has status indicator J1 and is assigned APC 5114.

     The OPPS Addendum A rate is $6,264.95 multiplied by 60% for an unadjusted labor amount of $3,758.97, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $3,629.29.

     The non-labor portion is 40% of the APC rate, or $2,505.98.

     The sum of the labor and non-labor portions is $6,135.27.

     The Medicare facility specific amount is $6,135.27 multiplied by 130% for a MAR of $7,975.85. The insurance carrier paid $7, 895.22. A balance of $80.63 remains and is due to the requestor. DWC Rule 134.403 (e) (3) states in pertinent part regardless of billed amount, reimbursement shal be the maximum allowable reimbursement (MAR) amount under subsection (f) of this section.,

2. DWC Rule 28 TAC §134.403 (g) states in pertinent part, implantables when billed separately by the facility or a surgical implant provider shall be reimbursed at the lesser of the manufacturer's invoice amount plus 10 percent of $1,000 per billed item add-on whichever is less, but not to exceed $2,000 in addon's per admission.

   The requestor's medical bill indicates fourteen billable implants. The "Final Report" implant log contained the following:

   - Entry 1 – Suture Ancho Swivelock AR-2324BCT-2, 3 units.
     Supported cost of $2,125.00 per BOX
   - Entry 2 – Anchor Sut 5.5mm x 14.7mm AR-1927BCF-3, 1 unit
     Supported cost of $1,700.00 per BOX

- Entry 3 – Anchor Sut AR-1927BCF, 1 unit. Supported cost of $1,625.00 per BOX
- Entry 4 – Anchor Sut 19.5mm x 3.5mm AR-1926BC, 4 units supported cost of $400 each.

The requestor failed to support the cost of each separately requested implant. No additional reimbursement 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 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 respondent must remit to requestor $80.63 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	April 21, 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.