Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Surgical Hospital

Respondent Name
East Tx Educational Ins Assn

MFDR Tracking Number
M4-22-2382-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
July 8, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 9, 2021	C1713	$2678.50	$0.00
November 9, 2021	C1781	$2945.80	$0.00
	Total	$5624.30	$0.00

Requestor's Position

The requestor did not submit a position statement with their request for Medical Fee Dispute Resolution (MFDR) but did submit a copy of their reconsideration that states in pertinent part, "According to TX workers compensation fee schedule the expected reimbursement for DOS 11/9/2021 is $13,570.87."

Amount in Dispute: $5,624.30

Respondent's Position

"Upon receipt of a corrected implant invoice, additional reimbursement can be determined."

Response submitted by: Claims Administrative Services, Inc

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:

- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation
- 256 -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 rate, plus a markup
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 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 implants rendered during an outpatient hospital procedure in November 2021. The insurance carrier packaged the requested implants and paid the surgical procedure at a higher percentage.

   Review of the submitted documentation found of the six implants submitted for separate reimbursement only three had invoices submitted to support the reported cost.

   DWC Rule 28 TAC §134.403 (f) (1), states in pertinent parts, 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 following minimal modifications shall be applied. The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent; unless a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

DWC Rule 28 TAC §134.403 (g) states. implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be 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.

Based on the above fee guideline, the Medicare facility specific reimbursement and payment of implants supported by invoices is as follows.

- Procedure code 29827 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 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 0.9707 for an adjusted labor amount of $3,648.83.

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

  The sum of the labor and non-labor portions is $6,154.81.

  The Medicare facility specific amount is $6,154.81 multiplied by 130% for a MAR of $8,001.25.

- Review of the submitted itemized statement and invoices found the following.
  - "Suture orthocord violet" as identified in the itemized statement no invoice found to support cost.
  - "Suture anchor 4.75 x 14m" as identified in the itemized statement no invoice found to support cost.
  - "Suture anchor swivelock" as identified in the itemized statement no invoice found to support cost.
  - "Anchors bone 3 w arthro" as identified in the itemized statement and labeled on the invoice as "anchors bone 3 w arthro" with a cost per unit of $600.00.
  - "Staple tendon arthroscop" as identified in the itemized statement and labeled on the invoice as "staple tendon arthroscopy" with a cost per unit of $300.00.
  - "Implant mesh bioinductiv" as identified in the itemized statement and labeled on the invoice as "implant mesh" with a cost per unit of $2,500.00

- The total net invoice amount (exclusive of rebates and discounts) is $3,400.00. 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 $340.00. The total recommended reimbursement amount for the implantable items is $3,740.00.

2. The total recommended reimbursement for the disputed services is $11,741.25. The insurance carrier paid $12,156.31. 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	August 29, 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.