TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Crescent Medical Center

Respondent Name
Dallas Area Rapid Transit

MFDR Tracking Number
M4-22-2659-01

Carrier's Austin Representative
Box Number 53

DWC Date Received
August 19, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 5, 2022	23410, 29822, 29826	0.00	$0.00
May 5, 2022	Rev 0278, Implants	$2,816.12	$1,637.43
May 5, 2022	Other	$0.00	$0.00
	Total	$2,816.12	$1,637.43

Requestor's Position

The requestor did not submit a position statement with their request for MFDR but did submit a copy of their reconsideration request which states, "We requested separate payment for the implants, REV 0278. When separate payment is requested for implants, the expected allowed for CPT 23410 is $9821.32. The expected allowed for the implants is $5,.445.00. Please reprocess the additional $2816.12."

Amount in Dispute: $2,816.12

Respondent's Position

"Carrier responds that they wish to uphold their decision on this billing. Provider was originally paid $12,450.20 with the implants. Provider sent in a reconsideration requesting implant reimbursement. This was sent and priced by Foresight. The reconsideration allowed implant

payment but made cpt code 23410 overpaid by $-562.57. Please see the attached EOR's. Carrier asks that this request for medical fee dispute resolution be dismissed."

Response submitted by: Hoffman Kelley Lopez LLP

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:

- 6981 – Charges for surgical implants are reviewed separately by ForeSight Medical. Please expect a detailed explanation of review for surgical implant charges directly from ForeSight Medical at 813-930-5346
- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- P13 – Payment reduced or denied based on Workers' compensation jurisdictional regulations or payment policies

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 additional payment of implants provided as part of an outpatient surgical procedure in May 2022. The insurance carrier reduced the charges based on workers'

compensation fee guidelines. The calculation of the rendered services per the applicable fee guideline is shown below.

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 (e) states in pertinent part, regardless of billed amount, when no specific fee schedule or contract reimbursement shall be the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

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 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 $6,397.05 multiplied by 60% for an unadjusted labor amount of $3,838.23, in turn multiplied by facility wage index 0.9552 for an adjusted labor amount of $3,666.28.

  The non-labor portion is 40% of the APC rate, or $2,558.82.

  The sum of the labor and non-labor portions is $6,225.10.

  The Medicare facility specific amount is $6,225.10 multiplied by 130% for a MAR of $8,092.63.

  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.

  The implants billed separately and supported by the implant log and invoices that indicate

cost are as follows.

- "Anchor peek Anchor Peek 4.5 Punchtac Knotless" as identified in the itemized statement and labeled on the invoice as "4.5 Knotless Lateral Anchor" with a cost per unit of $975.00 at 2 units, for a total cost of $1,950.00.
- "Anchor peek Anchor Peek 4.75 Punchtac Threaded" as identified in the itemized statement and labeled on the invoice as "4.75mm Medical Suture Anchor " with a cost per unit of $750.00 at 2 units, for a total cost of $1,500.00.
- "Suture shuttle wire loop" as identified in the itemized statement and labeled on the invoice as "shuttle wire loop" with a cost per unit of $500.00.
- "Tissue Trigenix human matrix" as identified in the itemized statement and labeled on the invoice as "Trigenix Human Connective Tissue" with a cost per unit of $1,500.00.

The total net invoice amount (exclusive of rebates and discounts) is $5,450.00. 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 $545.00. The total recommended reimbursement amount for the implantable items is $5,995.00.

2. The total recommended reimbursement for the disputed services is $14,087.63. The insurance carrier paid $12,450.20. The amount due is $1,637.43. 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 $1,637.43 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 Dallas Area Rapid Transit must remit to Crescent Medical Center $1,637.43 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	September 2, 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.