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

General Information

Requestor Name
Baylor Surgical Hospital

Respondent Name
Texas Mutual

MFDR Tracking Number
M4-23-0421-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
October 17, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 29, 2021	C1713	$657.82	$0.00
December 29, 2021	C1781	$2750.00	$0.00
December 29, 2021	23412	$43.49	$0.00
	Total	$3,451.31	$0.00

Requestor's Position

The requestor did not submit a position statement with the request for MFDR but did submit a copy of their reconsideration that states, "According to TX workers compensation fee schedule the expected reimbursement for DOS 12/29/2021 is $14, 121.83. Please note that implants should be reimbursed at manual cost plus 10%. Previous payment received totaled $10,670.52"

Amount in Dispute: $3,451.31

Respondent's Position

The Austin carrier representative for Texas Mutual is Texas Mutual. The representative was notified of this medical fee dispute on October 25, 2022.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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:

- 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding initiative or workers compensation state regulations/fee schedule requirements
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- P12 - Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Did the requestor support the cost of implants per applicable rule?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $657.82 for implants provided as part of an outpatient surgical procedure in December 2021.

   DWC Rule 134.403 (g) (1) states in pertinent part 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. 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. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

Review of the submitted documentation found insufficient evidence to support the requestor certified the cost. No additional payment is recommended.

2. 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 requestor is also seeking additional reimbursement of Code 23412 for date of service December 29, 2021 in the amount of $43.49. 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) (1) (B) 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*. When 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.

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 23412 has status indicator J1. This code is assigned APC 5114. The OPPS Addendum A rate is $5,981.95. This is multiplied by 60% for an unadjusted labor amount of $3,589.17, in turn multiplied by facility wage index 0.9707 for an adjusted labor amount of $3,484.01.

  The non-labor portion is 40% of the APC rate, or $2,392.78.

  The sum of the labor and non-labor portions is $5,876.79.

The Medicare facility specific amount is $5,876.79 multiplied by 130% for a MAR of $7,639.83.

The total recommended reimbursement for the disputed services is $7,639.83. The insurance carrier paid $7,895.22. 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	January 30, 2023 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.