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

General Information

Requestor Name
Baylor Orthopedic & Spine Hospital

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-23-0430-01

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 8, 2021	C1762	$4264.70	$4264.70
December 8, 2021	C9353	0.00	$0.00
December 8, 2021	64910	$39.57	$27.57
	Total	$4,304.27	$4292.27

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but rather a document titled "Reconsideration" addressed to the Texas Department of Insurance. This document states, "According to TX workers compensation fee schedule the expected reimbursement for DOS 12/08/2021 is $13,605.39."

Amount in Dispute: $4,304.27

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:

- A09 – DWC Rule 134.403(B)(2) & Medicare by definition of implantables does not encompass biologicals
- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment
- CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration
- CAC-18- Exact duplicate claim/service
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- CAC-198 – Precertification/authorization exceeded
- CAC-55 – Procedure/treatment is deemed experimental/investigational by the payer
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
- 768 – Reimbursed per O/P FG at 130%. Separate reimbursement for implantables (including certification) was requested per Rule 134.403(G)

Issues

1. Is the insurance carrier's denial supported?

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

3. Is the requester entitled to additional reimbursement?

Findings

1. The insurance carrier denied the implant submitted on the medical claim as Code C1762 – Connective tissue, human (includes fascia lata) as A09- DWC Rule 134.403(B)(2) & Medicare by definition of implantables does not encompass biologicals.

   Per DWC Rule 28 TAC §134.403(b)(2), "implantable" means an object or device that is surgically: (a)implanted, (b) embedded, (c) inserted, (d) or otherwise applied, and (e) related equipment necessary to operate, program and recharge the implantable.

   The respondent did not present any information to support the assertion that implantables do not encompass biologicals. In fact, the division notes Code C1762 is listed as a device on the Medicare Device Pass-Through Category List.

   Because Medicare payment policies regarding implanted device category codes does list Code C1762 as a device, the insurance carrier's denial is not supported.

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 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 64910 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 5432. The OPPS Addendum A rate is $5,700.29 multiplied by 60% for an unadjusted labor amount of $3,420.17, in turn multiplied by facility wage index 0.9552 for an adjusted labor amount of $3,266.95.

  The non-labor portion is 40% of the APC rate, or $2,280.12.

  The sum of the labor and non-labor portions is $5,547.07.

  The Medicare facility specific amount is $5,547.07 multiplied by 130% for a MAR of $7,211.19.

  The requestor is seeking additional reimbursement for the implants listed below.

  - "Graft allograft" as identified in the itemized statement and labeled on the invoice as "Graft Allograft Nerve 3.0 to 4.0 x 30mm" with a cost per unit of $3,877.00.

  - "Nerve Connector" as identified in the itemized statement and labeled on the invoice as "Nerve Connector AGx415" with a cost per unit of $1,925.00.

  The total net invoice amount (exclusive of rebates and discounts) is $5,802.00. 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 $580.20.

  The total recommended reimbursement amount for the implantable items is $6,382.20.

2. The total recommended reimbursement for the disputed services is $13,593.39. The insurance carrier paid $9,301.12. The amount due is $4,292.27. 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 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 Texas Mutual must remit to Baylor Orthopedic & Spine Hospital $4,292.27 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 11, 2023
Signature	Medical Fee Dispute Resolution Officer	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.