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
Crescent Medical Center

Respondent Name
Tx Public School WC Project

MFDR Tracking Number
M4-23-0961-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
December 29, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 11, 2022	CPT 23472	13311.82	$188.61
October 11, 2022	Implants, Rev 0278	17825.00	$0.00
October 11, 2022	Other	0.00	$0.00
	Total	31136.82	$188.61

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a copy of their reconsideration that states, "We are requesting a reconsideration for the attached bill for underpayment. The expected allowed was $31,136.82. (APC rate + Texas state mark up) Creative only allowed $16,756.21."

Amount in Dispute: $31,136.82

Respondent's Position

"For the reasons noted above, CRF contends that it properly paid the surgical bill and implants in question Consequently, Crescent is not entitled to any additional payment in this claim at this time."

Response submitted by: Creative Risk Funding

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:

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 97 – The benefit for this service is included in the paymentallowance for another service procedure that has already been adjudicated
- P12 – Workers compensation jurisdictional fee schedule adjustment

Issues

1. Did the requestor support the cost of implants per applicable rule?
2. What rule is applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for the implants provided as part of an outpatient hospital surgery in October of 2022. The insurance carrier reduced the allowed amount based on workers' compensation fee schedule.

   Dwc Rule 28 TAC § 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 of all the implants listed on the itemized bill only the "Kit Plasma Platelet Rich" with a quantity of (1) and billed amount of $7,500.00 was supported by the required manufacturers invoice that indicates a cost of $750.. The insurance carrier paid $825.00 which is per fee guideline. No additional reimbursement is recommended.

2. The requestor is also seeking additional reimbursement for CPT Code 23472. The insurance carrier reduced the allowable based on workers compensation fee guidelines.

   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 23472 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 5115. The OPPS Addendum A rate is $12,593.29 multiplied by 60% for an unadjusted labor amount of $7,555.97, in turn multiplied by facility wage index 0.9744 for an adjusted labor amount of $7,362.54.

  The non-labor portion is 40% of the APC rate, or $5,037.32.

The sum of the labor and non-labor portions is $12,399.86.

The Medicare facility specific amount is $12,399.86 multiplied by 130% for a MAR of $16,119.82.

3. The total recommended reimbursement for the disputed services is $16,944.82. The insurance carrier paid $16,756.21. The amount due is $188.61. This amount is recommended.

Conclusion

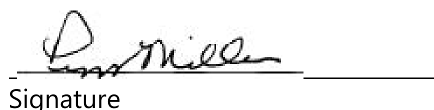
The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement $188.61 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 $188.61 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature



Signature	Peggy Miller Medical Fee Dispute Resolution Officer	February 14, 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.