



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Baylor Surgical Hospital at Trophy Club

**Respondent Name**

TASB Risk Management Fund

**MFDR Tracking Number**

M4-23-1055-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

January 9, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 18 2022	C1713	\$3026.65	\$0.00
April 18, 2022	C1781	\$2945.80	\$344.38
	Total	\$5972.45	\$344.38

### Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a document titled "Reconsideration" addressed to Texas Depart of Insurance dated December 28, 2022 that states, "Per the EOB payment has been denied for missing implant invoice."

**Amount in Dispute:** \$5972.45

### Respondent's Position

The Austin carrier representative for TASB Risk Management Fund is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on January 18, 2023.

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.

**Response submitted by:**

**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
- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation
- 350 – Bill has been identified as a request for reconsideration or appeal
- 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. Did the requestor support the separate reimbursement of implants?
2. What rule is applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement of implants rendered as part of an outpatient hospital surgery. DWC Rule 28 TAC §134.403 (g) 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.

(1) 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 medical bill found a separate request was made and the required billing certification and invoices were included. The calculation of the MAR will be based on DWC Rule 28 §134.403 (f)(1)(B) which states in pertinent part, 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.

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](http://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 (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 23412 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.

- Procedure code 29822 also has a status indicator of J1 but the applicable Medicare payment policy only allows payment of the highest ranking J1 code. Code 23412 has a ranking of 554, Code 29822 has a ranking of 1,720. Only code 23412 is eligible for reimbursement.

The implants supported by the operative report and invoices include.

- "Anchors bone 3 2/arthro dekl sys advcd Smith & Nephew" with a cost per unit of \$978.50;
- "Implant mesh bionductive with arthroscopic delivery system" with a cost per unit of \$2,678.00;
- "Staple tendon arthroscopy rotator cuff repair rotation medical" with a cost per unit of \$618.00;
- "Corkscrew 5,5mm bc ft suturetape arthrex" labeled on the invoice as unit of measure box. No payment recommended as no cost for each of the item was provided."
- "Anchor sut 19.55 x 3.5mm". No invoice supporting the cost was submitted. No payment recommended.

The total net supported invoice amount (exclusive of rebates and discounts) is \$4,274.50. 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 \$427.45. The total recommended reimbursement amount for the implantable items is \$4,701.95.

3. The total recommended reimbursement for the disputed services is \$12,794.58. The insurance carrier paid \$12,450.20. The amount due is \$344.38. 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 \$344.38 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 TASB Risk Management

Fund must remit to Baylor Surgical Hospital at Trophy Club \$344.38 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### Authorized Signature

_____	_____	April 14, 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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).