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

General Information

Requestor Name
Texas Regional Medical Center

Respondent Name
Arch Insurance Co

MFDR Tracking Number
M4-23-1427-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 16, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 21, 2022	C1713	20,154.00	$0.00
March 21, 2022	C1762	3,080.00	$0.00
March 21, 2022	C1763	1,397.00	$0.00
	Total	$24,631.00	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a copy of a document titled "Reconsideration" that states "The charges were not paid correctly per TX workers comp fee schedule. According to TX workers compensation fee schedule the expected reimbursement for DOS 3/21/2022 is $41,477.93."

Amount in Dispute: $24,631.00

Respondent's Position

The Austin carrier representative for Arch Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on February 22, 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.

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:

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- Reconsideration explanation of benefits illegible

Issues

1. What rule(s) is applicable to reimbursement?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for implants submitted on the medical bill as codes,
    - C1713 – Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)
    - C1762 – Connective tissue, human (includes fascia lata)
    - C1763 – Connective tissue, nonhuman (includes synthetic)

   The insurance carrier paid the medical bill 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)(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*. The following minimal modifications shall be applied. The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent unless a facility or surgical iplant provider requests separate reimbursement in accordance with subsection (g) the facility specific reimbursement amount shall be multiplied by 130 percent. Review of the submitted medical bill found separate reimbursement of implants was requested

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.

- Per Medicare policy, procedure code has a status indicator of S and is packaged into primary J1 procedure. Separate payment is not recommended.
- Procedure code 20680 has status indicator Q2 and is packaged into primary J1 procedure,
- Procedure code 20692 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. This is multiplied by 60% for an unadjusted labor amount of $7,555.97, in turn multiplied by facility wage index 0.9552 for an adjusted labor amount of $7,217.46.

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

  The sum of the labor and non-labor portions is $12,254.78.

  The Medicare facility specific amount is $12,254.78 multiplied by 130% for a MAR of

$15,931.21.

- Per Medicare policy found in the CMS Claim Processing Manual, Chapter 4 when more than one J1 procedure code is submitted on a medical bill only the highest ranking code receives payment. The following three codes have J1 status indicators.
    - 29692 with a ranking of 107
    - 27606 with a ranking of 1,949
    - 27700 with a ranking of 511

  Only Code 20692 is eligible for payment.

The following items were billed on the outpatient hospital bill under Revenue Code 278.

- "Wire fixation bolt" as identified in the itemized statement with a cost per unit of $7.00 at 8 units, for a total cost of $2,240.00;
- "Flat washer x 1mm" as identified in the itemized statement with a cost per unit of $7.00 at 24 units, for a total cost of $168.00;
- "Wing Bolt x 14mm" as identified in the itemized statement with a cost per unit of $140.00 at 2 units, for a total cost of $280.00;
- "Speed nut 900026" as identified in the itemized statement with a cost per unit of $7.00 at 12 units, for a total cost of $84.00;
- "Matrix Biocartilage" as identified in the itemized statement with a cost per unit of $1,400.00 at 2 units, for a total cost of $2,800.00;
- "Graft Nanobone SBX Putty" as identified in the itemized statement. An invoice supporting the cost was not found in the submitted documentation. No payment recommended.

The total net invoice amount (exclusive of rebates and discounts) is $5,677.00. 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 $567.70. The total recommended reimbursement amount for the implantable items is $6,244.70.

2. The total recommended reimbursement for the disputed services is $22,175.91. The insurance carrier paid $27,884.36. 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	May 17, 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.