



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Orthopedic & Spine Hospital

Respondent Name

TASB Risk Management Fund

MFDR Tracking Number

M4-23-1806-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

March 23, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 1, 2022	C1713	\$4,394.54	\$0.00
September 1, 2022	C1781	\$3,025.00	\$317.43
	Total	\$7,419.54	\$317.43

Requestor's Position

The requestor did not submit a position statement with their request for MFDR but did submit a document titled "Reconsideration" addressed to the Texas Department of Insurance that states, "Please reconsider additional payment on the enclosed invoice for date of service 9/1/2022. According to TX workers compensation fee schedule the expected reimbursement for DOS 9/01/2022 is \$15,512.17."

Amount in Dispute: \$7,419.54

Respondent's Position

"This request will be standing on the previous allowance of \$12,450.20 and no additional allowance is recommended as there were no manufacturer's invoices attached to the request. The provider, on previous review for this date of service, did not ask for separate reimbursement

for implants neither on the form or by a letter, and paid at the implant at max rate correctly per the Fee Schedule.”

Response submitted by: TASB Risk Fund

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:

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjusted
- P12 – Workers’ compensation jurisdictional fee schedule adjustment
- W3 – Additional payment made on appeal/reconsideration

Issues

1. Is the respondent’s position supported?
2. Did the requestor support the cost of implants per applicable rule?
3. Is the requester entitled to additional reimbursement?

Findings

1. The respondent states “the provider did not ask for separate reimbursement for implants neither on the form of by a letter...” DWC Rule 28 TAC §134.403 (g) (2) states in pertinent part, A carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding 133.307(d)(2)(B) of this title.

The requestor is seeking separate reimbursement of the implants per the submitted DWC060. Based on the above the maximum allowable reimbursement for the implants will be calculated per DWC Rule 28 TAC §134.403 (f)(1)(B) which 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 130 percent."

2. DWC Rule 28 TAC §134.403 (g) states in pertinent part, (g) 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.

Review of the submitted medical claim and itemized invoice found the following items identified as implant.

- "Suture Anchor Swivelock" as identified in the itemized statement no invoice supporting cost was found. No additional payment is recommended.
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- "Suture Anchor Swivelock" as identified in the itemized statement no invoice supporting cost was found. No additional payment is recommended.
- "Fibertak RC Double-loaded" as identified in the itemized statement no invoice supporting cost was found. No additional payment is recommended.
- "Staple Tendon Arthroscope" as identified in the itemized statement and labeled on the invoice as "Staple tendon arthroscopy rotator cuff" with a cost per unit of \$650.00;
- "Anchors bone 3 2 arthro" as identified in the itemized statement and labeled on the invoice as "Anchors bone 3 2 arthro " with a cost per unit of \$850.00;
- "Implant mesh bioinductive" as identified in the itemized statement and labeled on the invoice as "Implant mesh bioinductive" with a cost per unit of \$2,750.00.

The total amount recommended for the reimbursement of the implants is \$4,675.00.

3. 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 29827 has a Status Indicator of J1 and the associated APC is 5114 with an allowable of \$6,397.05 multiplied by 60% equals \$3,838.23 multiplied by the wage index of 0.9552 equals the adjusted labor amount of \$3,666.28.

The non-labor cost is \$6,397.05 multiplied by 40% equals \$2,558.82

The sum of the labor and non-labor amounts equals \$6,225.10.

This amount is multiplied by 130% to reach a maximum allowable reimbursement of \$8,092.63.

The total recommended reimbursement for the disputed services is \$12,767.63. The insurance carrier paid \$12,450.20. The amount due is \$317.43. 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 \$317.43 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 Orthopedic & Spine Hospital \$317.43 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

April 28, 2023

Date

Medical Fee Dispute Resolution Officer

Signature

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 electrónico CompConnection@tdi.texas.gov.