



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Surgical Hospital

Respondent Name

Great American Spirit Insurance Co

MFDR Tracking Number

M4-23-2746-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

June 27, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 18, 2022	C1713	\$4059.00	\$0.00
November 18, 2022	C1781	\$2970.00	\$649.35
	Total	\$7,029.00	\$649.35

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of a document titled "RECONSIDERATION" addressed to the Texas Department of Insurance(TDI). Requests for reconsideration should be sent to the appropriate workers' compensation carrier not TDI. This document states, "The charges were not paid correctly per TX work comp fee schedule. According to TX workers compensation fee schedule the expected reimbursement for DOS 11/18/2022 is \$15,121.63. Please note that separate reimbursement was requested in Box 80 of UB-04 for implants, and should be reimbursed at manual cost plus 10% which implant invoices are enclosed for review."

Amount in Dispute: \$7,029.00

Respondent's Position

“Although there was some language on the medical bill concerning implant reimbursement, no invoices for them were attached. Thus, the facility is not requesting them separately. The CMS OOPS reimbursement is 200%. See Rule 134.403(f)(1)(A), which provides that the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200% unless the facility or surgical implant provider request separate reimbursement. In this case, there was no request separate reimbursement. Accordingly, the provider was paid 200%. The provider is not entitled to any additional payment.

Response submitted by: Flahive, Ogden & Latson

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.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- 5682 – Payment for this charge is not recommended without documentation of cost
- 90084 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

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 reimbursement of implants provided during an outpatient hospital procedure in November of 2022. The insurance carrier denied the implants as no documentation of cost.

DWC Rule 28 TAC §134.403(g)(1) states in pertinent parts, Implantables, when billed separately by the facility... shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount... plus 10 percent. A facility billing separately for an implantable shall include with the billing certification that the amount billed represents the actual cost."

Review of the requestor's submitted documentation found invoices related to the implants detailed on the hospital's itemized statement. The insurance carrier's denial is not supported. The disputed services will be reviewed per applicable fee guidelines.

2. 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. Because the requestor did seek separate reimbursement for the implants, the Medicare facility specific amount will be multiplied by 130% per DWC Rule 28 TAC 134.403 (f)(1)(B).

Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

- Procedure code 29824 has a status indicator of J1 but multiple J1 procedures were billed. Per Medicare payment policy found at www.cms.gov, Medicare Claims Processing Manual, Chapter 4, Section 10.2.3, "Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS **lower ranked comprehensive procedure codes** (status indicator J1). This code has a ranking of 1,792. Not the highest ranking J1 procedure. Service is bundled into highest ranking code 29827 (ranking 485).

- Procedure code 29826 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code 29827 has status indicator J1, for procedures paid at a comprehensive rate. This code has a ranking of 485. All covered services on the bill are packaged with the primary "J1" procedure.

This code is assigned APC 5114. The OPSS Addendum A rate is \$6,642.29 multiplied by 60% for an unadjusted labor amount of \$3,985.37, in turn multiplied by facility wage index 0.9562 for an adjusted labor amount of \$3,810.81.

The non-labor portion is 40% of the APC rate, or \$2,656.92.

The sum of the labor and non-labor portions is \$6,467.73.

The Medicare facility specific amount is \$6,467.73 multiplied by 130% for a MAR of \$8,408.05.

- Procedure code 29828 has a status indicator of J1 but multiple J1 procedures were billed. Per Medicare payment shown above only the highest ranking J1 code is paid. This code has a ranking of 576. Service is bundled into highest ranking code 29827.
- Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g).

The facility's total billed charges for the separately reimbursed implantable items are \$6,390.00.

Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below. Review of the submitted documentation found the following items identified as Revenue Code 278.

- "Anchor Fibertak RC Dbloa" as identified in the itemized statement and labeled on the invoice as "SP FiberTak Rc dbload Tape" with a cost per unit of \$565.00.
- "Staple Tendon Arthroscop" as identified in the itemized statement and labeled on the invoice as "Tendon Anchors 8" with a cost per unit of \$350.00.
- "Anchors Bone 3 w arthro" as identified in the itemized statement and labeled on the invoice as "Bone Anchors 3 w arthro del" with a cost per unit of \$650.00.
- "Suture Anchor Swivelock" as identified in the itemized however, no invoice was found to support the cost. Documents included with this request list this item as "Stock".
- "Implant Mesh Bioinductive" as identified in the itemized statement and labeled

on the invoice as "Bioinductive Implant w/arth" with a cost per unit of \$2,700.00.

The total billed amount supported by invoice is \$4,265.00.

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-ons per admission is \$426.50.

The total recommended reimbursement amount for the implantable items is \$4,691.50.

3. The total recommended reimbursement for the disputed services is \$13,099.55. The insurance carrier paid \$12,450.20. The amount due is \$649.35. 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 \$649.35 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 Great American Spirit Insurance Co., must remit to Baylor Surgical Hospital \$649.35 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	July 31, 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 electrónico CompConnection@tdi.texas.gov.