TDI 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**
St Lukes Baptist Hospital

**Respondent Name**
Amco Insurance Co

**MFDR Tracking Number**
M4-23-2755-01

**Carrier's Austin Representative**
Box Number 06

**DWC Date Received**
June 28, 2023

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| September 23, 2022 | A9150 | $0.00 | $0.00 |
| September 23, 2022 | A9150 | $0.00 | $0.00 |
| September 23, 2022 | A9150 | $0.00 | $0.00 |
| September 23, 2022 | C1781 | $0.00 | $0.00 |
| September 23, 2022 | 88302 | $0.00 | $0.00 |
| September 23, 2022 | 49653 | $2,273.00 | $0.00 |
| September 23, 2022 | 01999 | $0.00 | $0.00 |
| | Total | $2,273.70 | $0.00 |

## Requestor's Position

The requestor did not submit a position statement with their request for medical fee dispute resolution (MFDR). They did submit a copy of their reconsideration that states, "St. Lukes Baptist is requesting WORKERS COMP MISCELLANEOU [sic] review implantable TDI-DWC rules; updated claim and reprocess and issue the additional $3,387.53 due on Outpatient Implantables."

**Amount in Dispute:** $2,273.70

## Respondent's Position

"Carrier has been asked by Amco Insurance Company to respond to the above-referenced medical dispute. Amco sent the dispute to its audit company which provided its opinion that no additional payment is required. The explanation for the payment made is as follows…

Invoice amount = 440.34 x 110% Implant markup = **484.37**

5.167.69 x 60% x 0.8382 = 2,598.934

5,167.69 x 40% = 2,067.076

2,598.934 x 2,067.076 = 4,666.01

4,666.01 x 130% State markup = **6,065.81**

**Response submitted by:** Stone Loughlin & Swanson, LLP

## 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:

- 131 – Claim specific negotiated discount.
- 252 – An attachment other documentation is required to adjudicate this claim/service.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 18 – Exact duplicate claim/service.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

Issues

1. Did the respondent support a negotiated discount?

2. What rule is applicable to reimbursement?

3. Is the requester entitled to additional reimbursement?

Findings

1. The explanation of benefits submitted by the parties indicates a contracted rate and a PPO reduction was applied. The submitted documentation was insufficient in supporting the claimant was enrolled in a certified health network or a contract between the parties exists. These reductions will not be considered in this review.

2. The requestor is seeking additional reimbursement for outpatient hospital services. Review of the submitted reconsideration found the requestor seeks additional payment for implants. The following fee guidelines are applied.

   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. The health care provider sought separate reimbursement for implants. The Medicare facility specific amount will be multiplied by 130%.

- Procedure code 49653 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 5361. The OPPS Addendum A rate is $5,167.69 multiplied by 60% for an unadjusted labor amount of $3,100.61, in turn multiplied by facility wage index 0.841 for an adjusted labor amount of $2,607.61.
- The non-labor portion is 40% of the APC rate, or $2,067.08.
- The sum of the labor and non-labor portions is $4,674.69.
- The Medicare facility specific amount is $4,674.69. This is multiplied by 130% for a MAR of $6,077.10.
- Revenue Code 278 on the medical bill is for "Mesh Hernia Composite" identified in the itemized statement and labeled on the invoice as "Implant, mesh Hernia Composite" with a cost per unit of $440.34.
- The total net invoice amount (exclusive of rebates and discounts) is $440.34. 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-ons per admission is $44.03. The total recommended reimbursement amount for the implantable items is $484.37.

3. The total recommended reimbursement for the disputed services is $6,561.47. The insurance carrier paid $7,058.32. 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 entitled to $0.00 additional reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | July 31, 2023<br>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.