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
Baylor Orthopedic & Spine Hospital

Respondent Name
Technology Insurance Company Inc.

MFDR Tracking Number
M4-24-0109-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
September 14, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 6, 2022	C1713	$2,054.18	$2,054.18
Octob34 6, 2022	C1762	$2,431.00	$2,410.07
	Total	$4,485.18	$4,464.25

Requestor's Position

The requestor did not submit a position statement with this request for Medical Fee Dispute Resolution (MFDR). They submitted a document titled "Reconsideration" addressed to the Texas Department of Insurance (TDI). Requests for reconsideration must be sent to the correct workers' compensation carrier not TDI. This document states, "Please note that separate reimbursement was requested in Box 80 of UB-04 for implants, and should be reimbursed at manual cost plus 10%."

Amount in Dispute: $4,485.18

Respondent's Position

"…The Carrier has paid a total of $8,113.58. This amount was inclusive of the entire surgical procedure, the APC rate plus a markup. In conclusion, Requestor is not owed any additional

reimbursement for the surgical procedure."

Response submitted by: Downs Stanford

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 the payment for the disputed services with the following claim adjustment codes:

- 252 – An attachment/other documentation is required to adjudicate this claim/service.
- 253 – In order to review this charge please submit a copy of the certified invoice.
- 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.
- M127 – Missing patient medical record for this service.
- MA27 – Missing/incomplete/invalid entitlement number or name shown on the claim.
- MA30 – Missing/incomplete/invalid type of bill.
- N130 – Consult plan benefit documents/guidelines for information about restrictions for this service.
- N179 – Additional information has been requested from the member The charges will be reconsidered upon receipt of that information.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.

- U-3 – The billed service was reviewed by UR and authorized.

Issues

1. What rule is applicable to reimbursement?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking payment for implants rendered during a surgical procedure performed in an outpatient hospital setting.

   Review of the submitted medical bill found a request for separate reimbursement of implants was made and the invoices and certification of cost was included with the submitted documentation. The maximum allowable reimbursement for the disputed service when implant reimbursement is requested separately is shown below.

   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 29888 has status indicator J1.

     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 is multiplied by 130% for a MAR of $8,092.63.

DWC Rule 28 TAC §134.403(g) states, "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." The following items were submitted on the medical bill and itemized statement under Revenue Code 278.

- "Device Fixtn Femrl w/zi" as identified in the itemized statement and labeled on the invoice as "Device Fixtn Femrl w/ziploop" with a cost per unit of $1,229.95;
- "Screw Bone 10mm x 25mmin" as identified in the itemized statement and labeled on the invoice as "Screw Bone 10mm x 25mminterference" with a cost per unit of $318.75;
- "Screw Bone 10mm x 30mmin" as identified in the itemized statement and labeled on the invoice as "Screw Bone 10mm x 30mminterference" with a cost per unit of $318.75;
- "Allograft Tibialis Anter" as identified in the itemized statement and labeled on the invoice as "Graft - Rod Case" with a cost per unit of $2,210.00.

- The total net invoice amount (exclusive of rebates and discounts) is $4,077.45. 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 $407.75. The total recommended reimbursement amount for the implantable items is $4,485.20.

3. The total recommended reimbursement for the disputed services is $12,577.83. The insurance carrier paid $8,113.58. The amount due is $4,464.25. 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 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 Technology Insurance Company Inc must remit to Baylor Orthopedic & Spine Hospital $4,464.25 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 7, 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 electronico CompConnection@tdi.texas.gov.