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

General Information

Requestor Name
Baylor Orthopedic & Spine Hospital

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-24-0418-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
October 18, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 2 ,2023	C1713	$3,399.00	$0.00
May 2, 2023	C1781	$3,025.00	$166.44
	Total	$6,424.00	$166.44

Requestor's Position

The requestor did not submit a position statement with this request for Medical Fee Dispute Resolution (MFDR). They did submit a copy of their reconsideration that states, "This clean claim was billed requesting the surgical procedure be paid at 130% of CMS with separate reimbursement for our implants. **According to Texas Workers Compensation Rule 134.402 "Implantable devices are reimbursed at the providers cost plus 10% up to $1,000.00 per item or $2,000.00 per case**."

Amount in Dispute: $6,424.00

Respondent's Position

"The carrier at this time finds that the provider did not submit true implant manufacturer invoices only copies of purchase order, sales order, and screen shots of online implant ordering of

implants. These “orders” fail to show any possible rebates, discounts, or what the provider actually paid when the implant were received.”

Response submitted by Liberty Mutual

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:

- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- P12 – Workers’ compensation jurisdictional fee schedule adjustment.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

1. What rule is applicable to reimbursement?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor indicated at the time of reconsideration separate payment of implants rendered during a surgical procedure performed in an outpatient hospital setting was requested.

   The respondent states in pertinent part, “The carrier at this time finds that the provider did not submit true implant manufacturer invoices only copies of purchase order, sales order and

screen shots of online implant ordering of implants. …These "orders" fail to show any possible rebates, discounts, or what the provider actually paid when the implants were received."

Review of the submitted documentation found a "Smith+Nephew" sales order dated May 2, 2023 specific to the surgeon that performed the surgery and the injured worker. This sales order indicates the cost of three of the implants and indicates "Total Contract Price." The respondent's position is not supported. The maximum allowable reimbursement for the disputed service when separate implant reimbursement is requested 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 29827 has status indicator J1. All covered services on the bill are packaged with the highest ranking "J1" procedure.

  This code is assigned APC 5114. The OPPS Addendum A rate is $6,614.63 multiplied by 60% for an unadjusted labor amount of $3,968.78, in turn multiplied by facility wage index 0.9562 for an adjusted labor amount of $3,794.95.

  The non-labor portion is 40% of the APC rate, or $2,645.85.

  The sum of the labor and non-labor portions is $6,440.80.

  The Medicare facility specific amount is $6,440.80 multiplied by 130% for a MAR of $8,373.04.

- 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.

- "Anchors Bone 2 w/Arthro" as identified in the itemized statement and labeled on the invoice as "Bone Anchors 2/ Arthro del sys" with a cost per unit of $850.00;
- "Staple Tendon Arthroscope" as identified in the itemized statement and labeled on the invoice as "Tendon Anchors " with a cost per unit of $650.00;
- "Suture Anchor Swivelock" as identified in the itemized statement was not supported by invoice. No payment recommended.
- "Suture Anchor Swivelock" as identified in the itemized statement was not supported by invoice. No payment recommended.
- "Fibertak RC Double-loaded" as identified in the itemized statement was not supported by invoice. No payment recommended.
- "Implant mesh Bioinductive" as identified in the itemized statement and labeled on the invoice as "Bioinductive Implant w/arth LRG" with a cost per unit of $2,750.00.

The total net invoice amount (exclusive of rebates and discounts) is $4,250.00. 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 $425.00. The total recommended reimbursement amount for the implantable items is $4,675.00.

3. The total recommended reimbursement for the disputed services is $13,048.04. The insurance carrier paid $12,881.60. The amount due is $166.44. 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 LM Insurance Corp must

remit to Baylor Orthopedic & Spine Hospital $166.44 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 17, 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.