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

General Information

Requestor Name
Baylor Surgical Hospital

Respondent Name
Pennsylvania Manufacturers Indemnity Co

MFDR Tracking Number
M4-24-0804-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
December 5, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 20, 2023	C1713	$12336.00	$0.00
April 20, 2023	82306	$37.00	$0.00
April 20, 2023	29882	$0.00	$0.00
	Total	$10390.95	$0.00

Requestor's Position

"The attached claim was processed and paid incorrectly. Please recalculate the fee schedule allowed amounts on all surgical procedures making sure to use the correct national rate and the wage index for the city where the facility is located. This clean claim was bill requesting the surgical procedure be paid at 130% of CMS with separate reimbursement for our implants."

Amount in Dispute: $10390.95

Respondent's Position

"The carrier's position is that with the payment of $1366.91, the provider has been paid all the monies that the provider is entitled no additional monies are owed."

Response submitted by Flahive Ogden and 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 the payment for the disputed services with the following claim adjustment codes:

- 216 – Based on the findings of a review organization.
- 219 – Based on extent of injury.
- 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.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 876 - Reimbursement equals the amount billed.
- 926 – The recommended allowance is based on Medicare Clinical Lab schedule.
- 247 – A payment or denial has already been recommended for the service.
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 11 – The recommended allowance for the supply was based on the attached invoice.
- 4281 – Overpayment recoupment.
- PRHT – The PPO reduction was taken in accordance to the PHS or leased entity contract.

Issues

1. Were the respondent's denials supported?
2. What rule is applicable to reimbursement?
3. How is the reimbursement of implants calculated?
4. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of outpatient hospital services rendered in April 2023. The respondent submitted explanation of benefits citing extent of injury and IRO review. These denials were not maintained. The explanation of benefits also indicated a PPO contract. Review of the submitted documentation found insufficient evidence to support the injured worker was enrolled in a certified network. This reduction will not be considered in this review. The disputed services will be reviewed per applicable fee guidelines.
2. 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 82306 has a status indicator of Q4. Reimbursement is included with payment for the primary procedure. Separate payment is not recommended.
   - Procedure code 29882 has status indicator J1, for procedures paid at a comprehensive rate.

This code is assigned APC 5113. The OPPS Addendum A rate is $2,976.66 multiplied by 60% for an unadjusted labor amount of $1,786.00, in turn multiplied by facility wage index 0.9562 for an adjusted labor amount of $1,707.77.

The non-labor portion is 40% of the APC rate, or $1,190.66.

The sum of the labor and non-labor portions is $2,898.43.

The Medicare facility specific amount is $2,898.43 multiplied by 130% for a MAR of $3,767.96.

3. 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.

   Review of the submitted medical bill and itemized statement found the following items billed under Revenue Code 278 or implants. However, the submitted invoice indicates only (1) unit while the submitted medical bill and itemized statement indicate (4). Only one unit will be considered in this review.

   - "Kit Biocomposite Meniscas" as identified in the itemized statement and labeled on the invoice as "AR-4550BC Biocomposite, Meniscal Root Repair Kit" with a cost per unit of $2,834.00. .

   The total net invoice amount (exclusive of rebates and discounts) is $2,834.00. 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 $283.40. The total recommended reimbursement amount for the implantable items is $3,117.40.

4. The total recommended reimbursement for the disputed services is $6,885.36. The insurance carrier paid $5,622.95 on July 10, 2023 via check 10979364C and $1,366.91 on November 9, 2023 via check 11071343C for a total of $6,989.86. 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

		January 4, 2024
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.