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

General Information

Requestor Name
Resolute Health System

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-24-1039-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
January 15, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 9, 2023	0250	$25.00	$0.00
March 9, 2023	0278	$23920.00	$0.00
March 9, 2023	0360	$18328.10	$0.00
March 9, 2023	0370	$6191.00	$0.00
March 9, 2023	0636	$1007.00	$0.00
March 9, 2023	0710	$3552.00	$0.00
March 9, 2023	WC ADJUSTMENTS	-41674.38	$0.00
	Total	$11648.72	$0.00

Requestor's Position

"The Hospital provided the medically necessary services on the above dates of service. The Hospital billed Texas Mutual, but the bill was underpaid and not paid in accordance with Chapter 134 regarding the proper reimbursement for implantables. However, despite the Hospital's efforts and Request for Reconsideration Texas Mutual has not rendered proper payment."

Amount in Dispute: $11648.72

Respondent's Position

"Our position is that no payment is due."

Response submitted by: Texas 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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §133.10 sets out the billing requirements when requesting implant reimbursement.

3. 28 TAC §134.403 sets out the fee guidelines for outpatient hospital services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 217 – The value of this procedure is included in the value of another procedure performed on this date.
- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation.
- 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.
- 787 – Paid per O/P at 200%: Implants not applicable or separate reimbursement (With Cert) not requested per Rule 134.403(G).

Issues

1. Did the requestor correctly submit the request for implantables?

2. What rule is applicable to reimbursement?

3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement of outpatient hospital services rendered in March of 2023. In their position statement the requestor specifically states the rendered implants were not paid correctly.

   DWC Rule 28 TAC §133.10 (f)(2)(QQ) states, "(UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested." Review of the submitted medical bill found this field did not contain a request for separate reimbursement of the rendered implants. The disputed services will be reviewed per applicable fee guideline without separate reimbursement of the implants.

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 C1713 – Anchor/screw implant. No request for implants was found on medical bill. Payment included in payment of procedure.
   - Procedure code 29827 has status indicator J1, for procedures paid at a comprehensive rate.
   - 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 0.8489 for an adjusted labor amount of $3,369.10.

- The non-labor portion is 40% of the APC rate, or $2,645.85.
- The sum of the labor and non-labor portions is $6,014.95.
- The Medicare facility specific amount is $6,014.95 multiplied by 200% for a MAR of $12,029.90.
- Procedure code 29828 has status indicator J1 and is ranked 576 (rankings found at www.cms.gov, Addenda J). Code 29827 is ranked 485 which is the highest ranking and only payable comprehensive code.
- Procedure code 29824 has status indicator J1 and is ranked 1,792. This code is packaged into higher ranked J1 comprehensive code 29827.
- Procedure code J0171 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J0690 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J1100 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2405 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2704 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2795 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J3010 has status indicator N reimbursement is included with payment for the primary services.

2. The total recommended reimbursement for the disputed services is $12,029.90. The insurance carrier paid $12,029.90. No additional payment 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 not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled

to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 26, 2024 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.