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
Texas Council Risk Management Fund

MFDR Tracking Number
M4-24-0688-01

Carrier's Austin Representative
Box Number 43

DWC Date Received
November 20, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 11, 2023	C1713	$1,093.27	$0.00
July 11, 2023	C1762	$4,070.00	$0.00
July 11, 2023	C1769	$40.36	$0.00
July 11, 2023	27427	-4,508.56	$0.00
	Total	$695.07	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" that states, "According to TX workers compensation fee schedule the expected reimbursement for DOS 7/11/2023 is $13,576.67. Please note that separate reimbursement was requested in Box 80 of UB-04 form for implants, and should be reimbursed at manual cost plus 10%."

Amount in Dispute: $695.07

Respondent's Position

The Austin carrier representative for Texas Council Risk Management Fund is Sedgwick York Risk

Services. The representative was notified of this medical fee dispute on November 28, 2023.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Response submitted by: N/A

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 §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.

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 193 – Original payment decision is being maintained. Upon review, it was determined this claim was processed properly.

Issues

1. What rule is applicable to reimbursement?

2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of implants rendered during an outpatient hospital surgery on July 11, 2023. The insurance carrier reduced the disputed service based on packaging and workers' compensation fee schedule. The maximum allowable reimbursement (MAR) per the applicable fee guideline is found 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)(2) states in pertinent part, regardless of billed amount, if no contracted fee schedule exits that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables applies.

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 sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent. The requestor did make a request for separate implant reimbursement. The disputed services will be calculated and multiplied by 130%.

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 27427 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 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 §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 billed under Revenue Code 278.

- "Anchor Q-Fix 2.8MM" as identified in the itemized statement and labeled on the invoice as "2.8MM Q-FIX all suture anchor" with a cost per unit of $375.00;
- "Pin Passing 2.7MM 15IN" as identified in the itemized statement. Review of the submitted operative report does not support this item was implanted. No payment is recommended.
- "Screw 9MM x 20MM Biosure" as identified in the itemized statement and labeled on the invoice as "Screw Biosure Regenesorb 8mm" with a cost per unit of $260.00;
- "Screw Biosure 8MM x 20MM" as identified in the itemized statement and labeled on the invoice as "Screw Biosure Regensorb 9mm " with a cost per unit of $260.00;
- "Graft Bone Achilles Tend" as identified in the itemized statement. This item was not supported by an invoice but rather a screen shot of "Bosha Vendor delivered goods." No payment is recommended.
- "Wire Guide 1.2MM x 18IN" as identified in the itemized statement. Review of the submitted operative report does not support this item was utilized during the procedure. No payment is recommended.

The total net invoice amount (exclusive of rebates and discounts) is $895.00. 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 $89.50. The total recommended reimbursement amount for the implantable items is $984.50.

2. The total recommended reimbursement for the disputed services is $9,357.54. The insurance carrier paid $12,881.60. 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	March 14, 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.