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

General Information

Requestor Name
Memorial Hermann Specialty Hospital

Respondent Name
TASB Risk Management Fund

MFDR Tracking Number
M4-24-1231-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 1, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 18, 2023	C1713	$71.50	$71.50
September 18, 2023	C1776	$14,094.30	$3,681.74
	Total	$14,165.80	$3,753.24

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" dated January 11, 2024 that states, "According to TX Workers Compensation guidelines the expected reimbursement for DOS 9/14/2023 is $31,051.97. Per EOB received, payment was disallowed for Rev code 278/Implants being inclusive. Please note that separate reimbursement was requested in Box 80 of UB-04 for implants, and should be reimbursed at manual cost plus 10%. Implant invoices are enclosed for review. Previous payment received totaled $25,978.73. Please reprocess and remit payment for remaining balance due."

Amount in Dispute: $14,165.80

Respondent's Position

"Per the Texas Hospital Facility Fee Guideline Rule for Implants 134.403 no additional payment is to be issued as there has been no formal request for separate reimbursement of implants on any of the documentation received to date. Also, Box 80 is not referenced on any billings that have been received. We are standing on our previous review under bill#TSTX-322787 $25,978.73 check# 10305094 issued 10/27/2023."

Response submitted by: TASB Risk Fund

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.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 351 – No additional reimbursement allowed after review of appeal/reconsideration.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 375 – Please see special "NOTE" below.
- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 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.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use on if not other code is applicable.
- U03 – The billed service was reviewed by UR and authorized.
- W3 – In accordance with TDI-DWC Rule 134.804. This bill has been identified as a request for reconsideration or appeal.
- Per the Texas Hospital Facility Fee Guideline Rule for Implants 134.403 no additional payment is to be issued as there has been no formal request for separate reimbursement of implants on any of the documentation received to date. Also, Box 80 is not referenced on any billings that have been received.

Issues

1. Did the requestor make a request for separate reimbursement of implants?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment for implants rendered on September 18, 2023, as part of an inpatient hospital stay. DWC Rule 133.10 (f)(2)(QQ) states, "The following data content or data elements are required for a complete institutional medical bill related to Texas workers compensation health care: (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested."

   The insurance carrier states in their position statement that box 80 of the submitted medical bill had not been referenced. Review of the submitted medical bill with a creation date of January 11, 2024 found box 80 of the UB04 indicates, "Implant Reimbursement." The insurance carrier's statement/denial is not supported and the services in dispute 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)(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.

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. Review of the submitted medical bill found a request for implants was made. The Medicare facility specific reimbursement amount will be multiplied by 130 percent.

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 23472 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 5115. The OPPS Addendum A rate is $13,048.08 multiplied by 60% for an unadjusted labor amount of $7,828.85, in turn multiplied by facility wage index 0.9925 for an adjusted labor amount of $7,770.13.

  The non-labor portion is 40% of the APC rate, or $5,219.23.

  The sum of the labor and non-labor portions is $12,989.36.

  The Medicare facility specific amount is $12,989.36 multiplied by 130% for a MAR of $16,886.17.

- 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 under Revenue Code 278 on the medical bill and itemized statement.

  - "MV Bone Cement 40 Grams" as identified in the itemized statement and labeled on the invoice as "Rally MV Bone Cement 40 grams" with a cost per unit of

$65.00;

- "Prosthesis Humeral Head" as identified in the itemized statement and labeled on the invoice as "Perform Cocr Humeral Head 41x15" with a cost per unit of $1,200.00;
- "Prosthesis Fracture Hume" as identified in the itemized statement and labeled on the invoice as "Perform FX Centered Modular" with a cost per unit of $313.00;
- "Stem Fracture STD size 1" as identified in the itemized statement and labeled on the invoice as "Perform FX Stem SZ 11" with a cost per unit of $9,000.00;
- "Aequalios Perform Glenoid" as identified in the itemized statement and labeled on the invoice as "Tornier Perform anatomicglenoid Cortiloc" with a cost per unit of $1,100.00.

The total net invoice amount (exclusive of rebates and discounts) is $11,678.00. 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 $1,167.80. The total recommended reimbursement amount for the implantable items is $12,845.80.

3. The total recommended reimbursement for the disputed services is $29,731.97. The insurance carrier paid $25,978.73. The amount due is $3,753.24. 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 TASB Risk Management Fund must remit to Memorial Hermann Specialty Hospital $3,753.24 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 25, 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, 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.