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
Accident Fund General Insurance Co

MFDR Tracking Number
M4-24-1398-01

Carrier's Austin Representative
Box Number 6

DWC Date Received
February 26, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 6, 2023	C1713	$6,406.47	$680.14
	Total	$6,406.47	$680.14

Requestor's Position

The requestor did not submit a position statemen with this request for MFDR. They did submit a copy of their reconsideration dated February 17, 2024 that states, "According to TX Workers Compensation fee schedule the expected reimbursement for DOS 6/6/2023 is $14,779.51. Please note that per TX Rule 134.402, implants should be paid at manual cost plus 10%. Also, surgical code should be reimbursed at 130% GARR which the expected reimbursement for CPT code 24635 is $8,373.04."

Amount in Dispute: $6,406.47

Respondent's Position

"This firm has been asked by Accident Fund General Insurance Company to respond to the above-referenced medical dispute. After review of the dispute, Accident Fund determined that a payment of $12,881.60 has already been paid, but that an additional $680.14 is owed and will issue payment for that amount. ...we believe 22 implants is the correct number. Our calculation

of the 22 implants, per their charge sheet is $4717.00, plus 10% would be $5188.70. Also, due to separately reimbursing the implants, this affects the pricing of the primary procedure. Instead of 200% of Medicare, it reimburses at 130%. Therefore, bill should have paid $8373.04 (procedure) +5188.70 (implants) = $13,561.74 - $12,881.60 (previous payment) = $680.14 additional owed."

Response submitted by: Stone Loughlin Swanson

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.

- 252 – An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice remark Code that is not an ALERT).
- 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.

Issues

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

Findings

1. The requestor is seeking payment of implants rendered as part of an outpatient hospital surgery in June of 2023. The insurance carrier reduced the payment based on lack of documentation, packaging and workers' compensation fee schedule. The disputed service will be reviewed per applicable fee guidelines 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)(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 24635 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.

The implants submitted under Revenue Code 278 listed on the itemized bill, and supported

by an invoice and certification of cost are as follows.

- "Screw Cortical Locking" as identified in the itemized statement with a cost per unit of $78.00;
- "Screw Polyaxial Non Loc" as identified in the itemized statement with a cost per unit of $78.00 at 6 units, for a total cost of $468.00;
- "Screw Polyaxial Non Loc" as identified in the itemized statement with a cost per unit of $78.00 at 3 units, for a total cost of $234.00;
- "Screw Polyaxial Non Loc" as identified in the itemized statement with a cost per unit of $150.00;
- "Plate Distal Ulna Geminu" as identified in the itemized statement with a cost per unit of $1,107.00;
- "Peg Thrd Locking 2.3mm" as identified in the itemized statement with a cost per unit of $89.00;
- "Peg Thrd Locking 2.3mm" as identified in the itemized statement with a cost per unit of $89.00 at 2 units, for a total cost of $178.00;
- "Peg Thrd Locking 2.3mm" as identified in the itemized statement with a cost per unit of $89.00;
- "Peg Thrd Non-Locking 2" as identified in the itemized statement with a cost per unit of $89.00 at 4 units, for a total cost of $356.00;
- "Peg Thrd Non-Locking 2" as identified in the itemized statement with a cost per unit of $89.00;
- "Midshaft Ulna Plate 188m" as identified in the itemized statement with a cost per unit of $1,879.00;
- "Plate Distal Ulna Geminu" as identified in the itemized statement with a cost per unit of $1,107.00. The submitted operative report did not support a second distal plate. No reimbursement is recommended.

The total net invoice amount (exclusive of rebates and discounts) is $4,717.00. 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 $471.70. The total recommended reimbursement amount for the implantable items is $5,188.70.

2. The total recommended reimbursement for the disputed services is $13,561.74. The insurance carrier paid $12,881.60. The amount due is $680.14. 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 Accident Fund General Insurance Co must remit to Baylor Orthopedic & Spine Hospital $680.14 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	March 20, 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.