



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Crescent Medical Center

Respondent Name

LM Insurance Corp

MFDR Tracking Number

M4-24-1938-01

Carrier's Austin Representative

Box Number 60

DWC Date Received

May 3, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 5, 2024	24342	-4462.40	\$0.00
January 5, 2024	C1713,C1762-Implants-REV 0278	5535.20	\$0.00
January 5, 2024	OTHER	0.00	\$0.00
Total		1072.80	\$0.00

Requestor's Position

"We are requesting the MAR value of \$14,158.24. We requested separate payment for implants. Please pay the additional \$1072.80."

Supplemental Response June 14 2024

"The implant invoice and log was attached to the MFDR submission, along with the itemized statement. What else is needed to get the implants paid?"

Amount in Dispute: \$1072.80

Respondent's Position

"Please see attached."

Response submitted by: Downs Stanford

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 for requesting separate implant reimbursement on institutional medical bills.
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.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 5283-1 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract, or carrier decision.
- 6183 – The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- 6340 – Charge for this procedure exceeds the OPPS schedule allowance.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 5682-1 – Payment for this charge is not recommended without documentation of cost.

Issues

1. Did the health care provider request separate reimbursement of implants per applicable rule?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of implants rendered as part of outpatient surgical procedure in January of 2024. The insurance carrier denied the disputed service as for claim lacking information.

Per §133.10 (2)(QQ) states, "remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested." Review of the submitted bill found box 80 was left blank. The Division finds the insurance carrier's denial is supported.

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 exists 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.

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 24342 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 \$6,816.33 multiplied by 60% for an unadjusted labor amount of \$4,089.80, in turn multiplied by facility wage index 0.9331 for an adjusted

labor amount of \$3,816.19.

The non-labor portion is 40% of the APC rate, or \$2,726.53.

The sum of the labor and non-labor portions is \$6,542.72.

The Medicare facility specific amount is \$6,542.72 multiplied by 200% for a MAR of \$13,085.44.

The total recommended reimbursement for the disputed services is \$13,085.44. The insurance carrier paid \$13,085.44. 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 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

June 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, 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 electrónico CompConnection@tdi.texas.gov.