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

Requestor Name
Baylor Surgical Hospital at Trophy Club

Respondent Name
AIU Insurance Company

MFDR Tracking Number
M4-24-1971-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 9, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 1, 2023	C1713	$2,313.26	$0.00
November 1, 2023	L8699	$2,717.00	$0.00
	Total	$5,030.26	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. Rather, they submitted a document titled "Reconsideration" dated March 19, 2024 that states, "According to TX Workers Compensation guidelines the expected reimbursement for DOS 11/01/2023 is $13,385.75. Please note that separate reimbursement was requested in Box 80 of UB-04 form for implants. Per TX Rule 134.402, implants should be reimbursed at manual cost plus 10%, and implant invoices are enclosed for review. Previous payment received totaled $12,854.60. Please remit payment for remaining balance due."

Amount in Dispute: $5,030.26

Respondent's Position

The Austin carrier representative for AIU Insurance Co is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on May 14, 2024. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.403 sets out the acute care hospital fee guideline for outpatient services.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and costs does not warrant a separate payment or the payment status indicator determined the service is packaged or excluded from payment.
- 932 – Charge for this procedure exceeds the OPPS schedule allowance.
- 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.
- 247 – A payment or denial has already been recommended for this service.
- 18 – Exact duplicate claim/service.
- N111 – No appeal right except duplicate claim/service issue. This service was included in a claim that has already been previously billed and adjudicated.

Issues

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

Findings

1. The requestor is seeking payment for services represented by codes C1713 - Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable) and L8699 – Prosthetic implant, not otherwise specified. The insurance carrier denied the charges as being packaged into the primary procedure. The insurance carrier did not submit a position statement in response to this request for MFDR.

   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.

The Medicare facility specific allowable is shown below.

- Procedure code 29888 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 0.9528 for an adjusted labor amount of $3,781.45.

  The non-labor portion is 40% of the APC rate, or $2,645.85.

  The sum of the labor and non-labor portions is $6,614.63.

  The Medicare facility specific amount is $6,614.63 multiplied by 130% for a MAR of $8,599.02.

Review of the submitted medical bill found the following items billed under revenue code 278.

- Tightrope ABS 3 Hole But – billed price 298.10. Manufacturer's invoice submitted indicates a cost of $298.10
- Anchor Souble Loaded Swi – billed price 785.90. No invoice submitted to support the cost billed.
- Bone Anchor Tightrope – billed price 699.18. No invoice submitted to support the cost billed.
- Tightrope II ABS Implant – billed price 319.78. No invoice submitted to support the cost billed.
- Allograft FQL09571 Presu – billed price $2470.00. Manufacturer's invoice submitted indicates "FlexiGRAFT" cost of $2,470.00

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."

Based on the submitted documentation only the Allograft (L8999) and Tightrope ABS 3 Hole But (C1713) are supported by the required invoice.

The total net invoice amount (exclusive of rebates and discounts) is $2,768.10. 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 $276.81. The total recommended reimbursement amount for the implantable items is $3,044.91.

2. The total recommended reimbursement for the disputed services is $11,643.93. The insurance carrier paid $12,854.60. 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.

The DWC finds the requestor 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

		July 18, 2024
Signature	Medical Fee Dispute Resolution Officer	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.