TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Memorial Hermann Surgical

Respondent Name
Texas Department of Transportation

MFDR Tracking Number
M4-24-2034-01

Carrier's Austin Representative
Box Number 32

DWC Date Received
May 21, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 11, 2023	C1713	$7,204.08	$0.00
July 11, 2023	C1781	$2,904.00	$0.00
	Total	$10,108.08	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of a document titled "Reconsideration" dates April 17, 2024 that states, "According to TX Workers Compensation guidelines the expected reimbursement for DOS 7/11/2023 is $18,668.40."

Amount in Dispute: $10,108.08

Respondent's Position

"Based on a review of the bill and the submitted documentation a recommendation is being made in the amount of $3236.93 including interest. A copy of the explanation of benefits has been included for review."

Response submitted by: Injury Management Organization

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.
- 129 – Prio processing information appears incorrect.
- P12 – Worker compensation jurisdictional fee schedule adjustment.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 29 – The time limit for filing has expired.
- W3 – TDI Level 1 Appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title.

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 implantables rendered as part of outpatient surgery rendered in July of 2023. The insurance carrier originally denied the claim as being packaged. The denial for untimely filing was not upheld. The disputed services will be reviewed per applicable fee guidelines.

   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 29827 has a status indicator of J1 as does code 29823. The applicable Medicare payment policy allows for only the highest ranking J1 code to receive payment. Review of the applicable addenda J at www.cms.gov finds code 29827 has a ranking of 485. Code 29823 has a ranking of 1,776. Therefore, only code 29827 will receive payment.

  The APC associated with 29827 is 5114 with a payment rate of $6,614.63 multiplied by 60% is $3,967.78 multiplied by facility wage index of 0.9925 equals the labor adjustment amount of $3,939.01.

  The non labor rate is $2,645.85.

  Total Medicare facility specific allowable $6,584.86 multiplied by 130 per cent equals $8,560.32.

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." Review of the submitted medical bill and itemized statement found the following items billed under Revenue Code 278.

- Implant Sys Bioc Achille, billed amount $4,325.16. No invoice submitted to support cost. No payment recommended.
- Suture Anchor 5.5 x 24, billed amount $420.00. No invoice submitted to support cost. No payment recommended.
- Staple Tendon Arthroscope, billed amount $660.00. Submitted invoice indicates cost of $660.00. This amount multiplied by 10% equals $66.00. Total allowable $726.00.
- Anchors Bone 3 w arthro, billed amount $1,144.00. Submitted invoice indicates cost of $1,144.00. This amount multiplied by 10% equals $114.40. Total allowable $1,258.40.
- Implant Medium Bioinduct, billed amount $2,640.00. Submitted invoice indicates cost of $2,840.00. This amount multiplied by 10% equals $264.00. Total allowable $2,904.00.

2. The total recommended reimbursement for the disputed services is $8,560.43 plus implant reimbursement of $4888.40 equals total MAR of $13,448.72. The insurance carrier paid $16,400.65. 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 additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional 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, 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.