



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

TOPS Surgical Specialty Hospital

Respondent Name

Safety National Casualty Corp

MFDR Tracking Number

M4-25-0114-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

September 16, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 8, 2024	C1713	\$8,800.00	\$0.00
January 8, 2024	29882	\$25.98	\$0.00
Total		\$8,825.98	\$0.00

Requestor's Position

"Please note per TX Rule 134.402, implants should be reimbursed at manual cost plus 10%, and surgical code should be reimbursed at 130% GARR. Previous payment received totaled \$6,165.22."

Amount in Dispute: \$8,825.98

Respondent's Position

"...No additional monies are owed for the implant. ...No additional payment is due for CPT 29882."

Response submitted by Flahive, Ogden & Latson

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. DWC Rule 28 TAC §134.403 sets out the outpatient hospital facility fee guidelines.

Denial Reasons

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- U301 – This item has been reviewed on a previously submitted bill, or is currently in process. Notification of decision has been previously provided or will be issued upon completion of our review.
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 11 – The recommended allowance for the supply was based on the attached invoice.
- 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

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

Findings

1. The requestor is seeking additional payment of outpatient hospital services rendered in January of 2024. The insurance carrier reduced the allowed payment based on OPSS fee schedule, bundling and workers' compensation fee schedule.

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. 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.

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 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 29882 has a status indicator of J1. The associated APC is 5113 with a payment rate of \$3,084.03 multiplied by 60% is \$1,850.42 multiplied by facility wage index of 0.9817 equals the labor adjustment amount of \$1,816.56.

The non labor rate is \$1,233.61.

Total Medicare facility specific allowable \$3,050.17 multiplied by 130% equals MAR of \$3,965.22.

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

- "Suture implant system lo" as identified in the itemized statement and labeled on the invoice as "Implant system, Sutureloc" with a cost per unit of \$2,000.00.

The total net invoice amount (exclusive of rebates and discounts) is \$2,000.00. 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 \$200.00. The total recommended reimbursement amount for the implantable items is \$2,200.00.

3. The total recommended reimbursement for the disputed services is \$6,165.22. The insurance carrier paid \$6,165.22. 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 additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement in the amount of \$0.00 for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 31, 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.