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

General Information

Requestor Name
Trophy Club Medical Center

Respondent Name
Standard Fire Insurance Co

MFDR Tracking Number
M4-25-0147-01

Carrier's Austin Representative
Box Number 5

DWC Date Received
September 12, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 18, 2023	29827	$0.00	$0.00
October 18, 2023	C1713	$5503.44	$0.00
October 18, 2023	80048	$10.58	$0.00
October 18, 2023	36415	$3.75	$0.00
October 18, 2023	82947	$4.91	$0.00
October 18, 2023	85025	$9.71	$0.00
	Total	$765.58	$0.00

Requestor's Position

"This clean claim was billed requesting the surgical procedure be paid at 130% of CMS with separate reimbursement for our implants."

Amount in Dispute: $765.58

Respondent's Position

"On reconsideration, the Provider sought separate reimbursement for the implantables… The implantable produced separate reimbursement of $5,220, bringing total reimbursement for the admission to $13,575.49. The Carrier issued additional reimbursement of $720.89 to the Provider on reconsideration to cover the difference between this amount and the original reimbursement. With the original reimbursement and the additional reimbursement issued on reconsideration for the implantables, the Provider has been reimbursed a total of $13,580.33. …The remaining CPT codes are inclusive to the primary procedure under the appropriate Medicare edits. The Carrier contends the Provider is not entitled to additional reimbursement."

Response submitted by Travelers

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 reimbursement guidelines for outpatient hospital services.

Denial Reasons

- 97 – Payment adjusted because 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.
- W3 – Bill is a reconsideration or appeal.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 2008 – Additional payment made on appeal/reconsideration.

Issues

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

Findings

1. The requestor is seeking reimbursement of outpatient hospital surgical procedures and implants rendered October 18, 2023. The insurance carrier reduced the disputed services based on workers' compensation 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 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.

   At the time of reconsideration, the insurance carrier acknowledged a request for separate implant reimbursement. The Medicare facility specific reimbursement amount will be multiplied by 130 percent.

   DWC Rule 28 TAC §134.403 (g) 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 80048 has a status indicator of Q4 and is packaged into the primary J1 procedure. No payment is recommended.
- Procedure code 80050 has a status indicator of E1 and is not covered. No payment is recommended.
- Procedure code 36415 has a status indicator of Q4 and is packaged into primary J1 procedure. No payment is recommended.
- Procedure code 82947 has a status indicator of A and is packaged into the primary J1 procedure. No payment is recommended.
- Procedure code 85025 has a status indicator of Q4 and is packaged into primary J1 procedure. No payment is recommended.
- Procedure code 29827 has a status indicator of J1. The APC associated with 29827 is 5114 with a payment rate of $6,614.63 multiplied by 60% is $3,968.78 multiplied by facility wage index of 0.9552 equals the labor adjustment amount of $3,790.98.
- The non labor rate is $2,645.85.
- Total Medicare facility specific allowable $6,436.82 multiplied by 130% equals $8,367.88.

The following items were submitted on the medical bill and itemized statement under Revenue code 278.

- "Anchor Sut 4.75MM x 19.1" AR-2324BCCTT as identified in the itemized statement. Review of the submitted documentation did not find an invoice to support the cost of the implant. No reimbursement is recommended.
- "Anchor Sut 4.75MM x 19.1" AR-2324BCCT as identified in the itemized statement with a cost per unit of $509.48.
- "Anchor Sut 4.75MM x 19.1" AR-2324BCC as identified in the itemized statement with a cost per unit of $433.60 at 2 units, for a total cost of $867.20.

The total net invoice amount (exclusive of rebates and discounts) is $1,376.68. 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-ons per admission is $137.67. The total recommended reimbursement amount for the implantable items is $1,514.35.

3. The total recommended reimbursement for the disputed services is $9,882.23. The insurance carrier paid $13,575.49. No additional reimbursement 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

		October 31, 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.