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
Baylor Orthopedic & Spine Hosp

Respondent Name
Texas Mutual Insurance Co.

MFDR Tracking Number
M4-25-0624-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
November 13, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 23, 2024	C1713	$0.00	$0.00
	26540	$1,768.50 [*sic*]	$0.00
	Total	$1,319.70	$0.00

Requestor's Position

"We are disputing the allowed amount of the attached claim. On September 1, 2008 the Texas Workers Compensation Fee Schedule and Guidelines for Hospitals drastically changed. The Fee Schedule generally allows for greater reimbursement and the TWCC adopted Medicare/CMS Billing Guidelines and methodologies... The following is a breakdown of how this claim should have processed ....

"CPT 26540 allows $5629.08 (pays at 200%) = $5629.08

Claim Allowed Total = $5629.08

Less payment made of $4309.38

** We are owed an additional payment of $1,319.70"

Amount in Dispute: $1,319.70

Respondent's Position

"On the UB-04, the health care provider requested separate reimbursement for implants meaning the bill would be paid at 130% of the APC/OPPS rate in addition to the implant reimbursement at invoice cost plus 10%. Reimbursement was made as requested to the health care provider. Our position is that no additional payment is due."

Response submitted by: Texas Mutual Insurance Co.

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.

Adjustment Reasons

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

- 370 - THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
- 768 - REIMBURSED PER O/P FG AT 130% SEPARATE REIMBUSEMENT FOR IMPLANTABLES (INCLUDING CERTIFICATION) WAS REQUESTED PER RULE 134.403(G).
- 897 - SEPARATE REIMBURSEMENT FOR IMPLANTABLES MADE IN ACCORDANCE WITH DWC RULE CHAPTER 134; SUBCHAPTER (E) HEALTH FACILITY FEES.
- P12 – Workers' Compensation Jurisdictional fee schedule adjustment.
- W3 & 350 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

1. Have the services in dispute been previously reimbursed?
2. Did the insurance carrier reimburse the disputed services in accordance with the applicable DWC Rule 28 TAC §134.403?
3. Is the requester entitled to additional reimbursement?

Findings

1. Per review of the submitted explanation of benefits (EOB) dated March 29, 2024, the insurance carrier previously issued a payment in the amount of $448.80 for one unit of surgical implant code C1713, and in the amount of $3,860.58 for procedure code 26540, surgical repair of a hand joint.

   DWC finds that the outpatient surgical services in dispute have been previously reimbursed in the total amount of $4,309.38.

2. The requester is seeking additional reimbursement in the amount of $1,319.70 for outpatient facility charges rendered January 23, 2024.

   DWC Rule 28 TAC §134.403 (d), which applies to the services in dispute, 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) states in pertinent part, regardless of billed amount, when no specific fee schedule or contract exists, reimbursement shall be 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 following minimal modifications shall be applied. (1) 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…

(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-ons per admission."

According to a review of the submitted medical bills created on February 22, 2024, and on July 17, 2024, DWC finds that the requestor did request separate reimbursement for surgical implants. Therefore, the MAR for the disputed procedure code 26540, shall be the Medicare facility specific reimbursement amount multiplied by 130 percent with separate reimbursement for implants.

DWC finds that the insurance carrier reimbursed the disputed services in accordance with DWC Rule 28 TAC §134.403.

3. The requestor is seeking additional reimbursement in the amount of $1,319.70 for outpatient surgical services rendered January 23, 2024. Specifically, the requestor is seeking additional reimbursement for procedure code 26540.

   CPT code 26540 is described as surgical repair of a hand joint and has a payment status indicator of J1. For codes designated with payment status indicator J1, a single payment is provided for the primary service, and payment for all adjunctive services reported on the same claim are packaged into the payment for the primary service.

   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 in accordance with the applicable fee guidelines referenced above is shown below.

   For procedure code 26540:

   - Procedure code 26540 has status indicator J1, for outpatient comprehensive packaging.
   - This code is assigned APC 5113. The OPPS Addendum A rate is $3,084.03 multiplied by 60% for an unadjusted labor amount of $1,850.418, in turn multiplied by facility wage index 0.9382 for an adjusted labor amount of $1,736.062.
   - The non-labor portion is 40% of the APC rate, or $1,233.612.
   - The sum of the adjusted labor amount and the non-labor portion is $2,969.674. Therefore, the Medicare facility specific amount is $2,969.674.
   - The facility provider requested separate reimbursement for implantable items on the medical bill. Therefore, in accordance with 28 TAC §134.403 the Medicare facility specific amount is multiplied by 130% for a MAR of $3,860.58.

- A review of the submitted EOB finds that the insurance carrier allowed reimbursement in the amount of $3,860.58 for procedure code 26540.

For separate implant reimbursement:

- Per the submitted itemized statement, the requestor charged for implantable items billed under code C1713 in the amount of $2,856.00.
- A review of the submitted operative report, implant log and implant invoice, finds that the following products were implanted: Arthrex 2.2mm corkscrew anchor x one unit.
- Arhtrex 2.2mm corkscrew anchor x one unit billed under procedure code C1713 and revenue code 278, has a supported cost of $408.00.
- Supported cost of one unit of the implant plus 10% is $408.00 + $40.80 = $448.80 implant MAR.
- A review of the submitted EOB dated March 29, 2024, finds that the insurance carrier allowed reimbursement for the implant billed under code C1718 in the amount of $448.80.

Total MAR for outpatient surgery services rendered on the disputed date:

- DWC finds that the total MAR for outpatient surgery services rendered on the disputed date of service is $4,309.38.
- A review of the submitted EOBs finds that the insurance carrier allowed payment in the total amount of $4.309.38 for the disputed outpatient surgical services rendered on January 23, 2024.
- Additional reimbursement 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 that the requestor 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	February 11, 2025 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.