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

General Information

Requestor Name
Baylor Medical Center at Uptown

Respondent Name
Berkley Casualty Co

MFDR Tracking Number
M4-25-1274-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 11, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 16, 2024	C1713	$6,628.64	$3,887.40
May 16, 2024	27792	$255.17	$0.00
	Total	$6,883.81	$3,887.40

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" dated February 3, 2025 that states, "Per EOB received payment was disallowed for payment for CPT code C1713. Please note that separate reimbursement was requested in Box 80 of billing form for implants, and should be reimbursed at manual cost plus 10%."

Amount in Dispute: $6,883.81

Respondent's Position

"We have been retained by Berkley Casualty to respond on its behalf to this medical dispute. After review of the dispute, Berkley has elected to stand by the audit performed and the reimbursement issued to date.

Response submitted by: Stone Loughlin Swanson

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 billing and reimbursement guidelines for outpatient hospital services.

Denial Reasons

- 252 – An attachment/other documentation is required to adjudicate this claim/service.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 253 – In order to review this charge please submit a copy of the certified invoice.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- P11 – Allowance was reduced as per contractual agreement.

Issues

1. Did the respondent support contractual reduction/denial of implants?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment of implants rendered as part of an outpatient surgical procedure performed on May 16, 2024. The submitted explanation of benefits indicates a contractual agreement reduction. Review of the submitted documentation and information known to the Division does not support the injured worker is enrolled in a certified health network. The reduction based on contract is not supported. The implants were denied for lack of certified invoice. The information submitted with the request for MFDR included a manufacturer's invoice and certification of cost. The applicable fee guideline is shown below.

2. 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.

   (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 are shown below.

   - Procedure code 27829 has a status indicator of J1 as does codes 27792, 29891 and 29898. 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 27829 has a ranking of 523. Codes 27792 has a ranking of 583, 29891 has a ranking of 1,724 and code 29898 has a ranking of 1,794. Therefore, only code 27829 would receive payment. The combination of billed codes does not trigger a complexity adjustment. The code listed on the DWC 60 indicates code 27792 as being in dispute.

As shown above, this code is not the highest ranking as does not receive reimbursement. No payment is recommended.

The following items were billed under Revenue Code 278.

- "Screw bone 3.5mm x 14mm" as identified in the itemized statement with a cost per unit of $100.00 at 4 units, for a total cost of $400.00;
- "Plate tubular 8 holelcok" as identified in the itemized statement with a cost per unit of $442.00;
- "Screw low profile 3.5mm" as identified in the itemized statement with a cost per unit of $100.00 at 2 units, for a total cost of $200.00;
- "Implant TI syndesmosis " as identified in the itemized statement with a cost per unit of $2,492.00. (Two units submitted but "Implant/Charge Log" indicates one unit was in & out. Only one unit was supported by operative report as being implanted.

The total net invoice amount (exclusive of rebates and discounts) is $3,534.00. 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 $353.40. The total recommended reimbursement amount for the implantable items is $3,887.40.

3. The total recommended reimbursement for the disputed services (implants) is $3,887.40. This amount 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 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 for the disputed services. It is ordered that Berkley Casualty Co must remit to Baylor Medical Center at Uptown $3,887.40 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 17, 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.