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 Surgical Hospital

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-22-1220-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
February 12, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 14, 2021	X9907	$3,677.38	3272.10
April 14, 2021	278	$474.00	$474.00
	Total	$4,151.38	$3,746.10

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "Please reconsider additional payment for Rev code 278/Implants which implant invoices are enclosed for review of additional payment, and implants should be paid t manual cost plus 10%."

Amount in Dispute: $4,151.38

Respondent's Position

Our Fee Schedule team has determined that the provider is not due any additional allowance.

Response Submitted by: Gallagher Bassett

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 §134.404 sets out the acute care hospital fee guideline for inpatient services.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.404 sets out the fee guidelines for inpatient services.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 5920 – Fee Schedule manually priced at billed charge.

Issues

1. What rule is applicable to disputed charges?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards inpatient hospital facility services with payment subject to 28 TAC §134.404(f), requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Inpatient Prospective Payment System (IPPS) formulas and factors, as published annually in the Federal Register, with modifications set forth in the rules. Medicare IPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   The division calculates the Medicare facility specific amount using Medicare's *Inpatient PPS PC Pricer* as a tool to efficiently identify and apply IPPS formulas and factors. This software is freely available from www.cms.gov.

   Note: the "VBP adjustment" listed in the *PC Pricer* was removed in calculating the facility amount for this admission. Medicare's Value-Based Purchasing (VBP) program is an initiative to improve quality of care in the Medicare system. However, such programs conflict with Texas Labor Code sections 413.0511 and 413.0512 regarding review and monitoring of health care quality in the Texas workers' compensation system. Rule §134.404(d)(1) requires that specific Labor Code

provisions and division rules take precedence over conflicting CMS provisions for administering Medicare. Consequently, VBP adjustments are not considered in determining the facility reimbursement.

Review of the submitted documentation finds that separate reimbursement for implants was requested; for that reason, the MAR is calculated according to §134.404(f)(1)(B).

Billed charges	Implant charge	Amount entered into PPS Pricer	Total DRG payment	Less VPB adjustment	Multiplied by 108%
$37,034.12	$4740.00	$32,294.12	$13,318.99	-$381.28	$13,937.31

Per §134.404(f)(1)(B), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 108%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 522. The services were provided in Fort Worth, Texas. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount after VPB is $13,937.31. This amount multiplied by 108% results in a MAR of $13,972.73.

Implants, 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 documentation finds that the separate implants include:

Item	Billed Amount	Cost	Units
• Screw Bone 20mm	$111.00	$111.00	1
• Screw Bone 35mm	$111.00	$111.00	1
• Screw Bone 25mm	$111.00	$111.00	1
• Stem Standard	$1,900.00	$1,900.00	1
• Head Femoral 36mm	$900.00	$900.00	1
• Cover Hole Threaded	$82.00	$82.00	1
• Shell Actblr	$900.00	$900.00	1
• Liner Actblr	$625.00	$625.00	1

The total net invoice amount (exclusive of rebates and discounts) is $4740.00. 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 $471.00. The total recommended reimbursement amount for the implantable items is $5214.00.

2. The total recommended payment for the services in dispute is $19,186.73. This amount less the amount previously paid by the insurance carrier of $15,440.63 leaves an amount due to the requestor of $3,746.10. 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 $3,746.10 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is [not] entitled to additional reimbursement for the disputed services. It is ordered that Old Republic Insurance Co must remit to Baylor Surgical Hospital $3,746.10 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 4, 2022
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.