



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Orthopedic & Spine Hospital

Respondent Name

TASB Risk Management Fund

MFDR Tracking Number

M4-23-1611-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

March 9, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 25, 2022	111-278	\$12,429.88	\$6,633.61
August 25, 2022	X9907	\$2,954.23	\$0.00
Total		\$15,384.11	\$6,633.61

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a document titled "Reconsideration" with a date of March 9, 2023, which is the same date as the request was sent to MFDR. This document asks for payment of the IPPS pricer calculation for the DRG times 108% and implants at manual cost plus 10%.

Amount in Dispute: \$15,384.11

Respondent's Position

"This request will be standing on the previous allowance of \$21,866.70, and no additional allowance is recommended as the provider has now requested separate reimbursement for implants. However, the provider did not follow rule 134.404 (g)(1) when requesting separate reimbursement for implants, therefore the bill was calculated at the higher percentage of 143%."

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.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Is the respondent's position statement supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for implants rendered at the time of an inpatient hospital stay. The insurance carrier's position statement states, "...the provider did not follow rule 134.404 (g)(1) when requesting separate reimbursement for implants."
DWC Rule §134.404 (g)(2) states in pertinent part, "A carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding §133.307(d)(2)(B) of this title." The requestor made a request for separate reimbursement of implants at MFDR and submitted applicable invoices and cost certification. The services in dispute will be reviewed per applicable fee guidelines.
2. 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.

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).

3. DWC Rule §134.404(f)(1)(B), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 108%. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 483. The services were provided at Arlington, Texas. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is \$15,291.40. This amount multiplied by 108% results in a MAR of \$16,514.71.

Review of the submitted medical bill found the requestor submitted fourteen implants in the amount of \$18,851.00. Review of the submitted operative report found the physician documented "Implants used, Tornier Revive reverse total shoulder, arthroplasty system 13 x 150 humeral stem, low offset metaphyseal tray, +9 mm polyethylene insert, #33 glenosphere, #25 +3 lateralized baseplate, 35-mm central compression screw, and four peripheral, two locking and two nonlocking screws." These implants are priced as follows.

- Tornier Revive reverse total shoulder, \$1,000.00.
- Arthroplasty system 13 x 150 humeral stem, \$4,296.00.
- Low offset metaphyseal tray, \$900.00.
- +9 mm polyethylene insert, no invoice supporting cost submitted.
- #33 Glenosphere, \$2,200.00.
- #25 + 3 lateralized baseplate, \$2,200.00.
- 35-mm central compression screw, no invoice supporting cost submitted.
- Four peripheral screws. Two locking two nonlocking, \$400.00.

The total net invoice amount (exclusive of rebates and discounts) is \$10,796.00. 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 \$1,089.60. The total recommended reimbursement amount for the implantable items is \$11,985.00.

The total recommended payment for the services in dispute is \$28,500.31. This amount less the amount previously paid by the insurance carrier of \$21,866.70 leaves an amount due to the requestor of \$6,633.61. 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 [not] entitled to additional reimbursement for the disputed services. It is ordered that TASB must remit to Baylor Orthopedic & Spine Hospital \$6,633.61 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 6, 2023
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 electrónico CompConnection@tdi.texas.gov.