



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Surgical Hospital

Respondent Name

Hartford Casualty Insurance Co

MFDR Tracking Number

M4-23-1952-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

April 7, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 20, 2022	111-278	\$4272.87	\$732.36
April 20, 2022	X9907	\$509.43	\$0.00
Total		\$4782.30	\$732.36

Requestor's Position

The requestor did not submit a position statement with this request for MFDR rather a document titled "Reconsideration" addressed to the Texas Department of Insurance.

Amount in Dispute: \$4782.30

Respondent's Position

"...Foresight is disagreeing with the provider that an additional allowance is due for the implants. Provider is misapplying the Texas Statute and expects to be reimbursed more than what was charged/billed for the Implants... As such, Foresight contends the provider has been adequately compensated for the implants with a total allowance of \$10,012.34."

Response Submitted by: Foresight

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:

- 131 – Claim specific discount
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 18 – Duplicate claim/service
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly

Issues

1. Is insurance carrier's reduction supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for inpatient hospital services including the implants rendered as part of the stay. The insurance carrier reduced the disputed services per claim specific discount. Review of the documentation found insufficient evidence to support any such discount exists. The disputed services will be reviewed per applicable fee guidelines.
2. This dispute regards inpatient hospital facility services with payment subject to DWC Rule 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 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 implantables was requested; for that reason, the MAR is calculated according to §134.404(f)(1)(B).

DWC Rule §134.404(g) states in pertinent part, 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.

Review of the submitted documentation finds the lines billed under Revenue Code 278 include:

- "Screw bone" as identified in the itemized statement and labeled on the invoice as "Set screw" with a cost per unit of \$25.00 at 4 units, for a total cost of \$100.00;
- "Rod" as identified in the itemized statement and labeled on the invoice as "Pre-Lordosed Rod" with a cost per unit of \$150.00 at 2 units, for a total cost of \$300.00;
- "Screw 7.5" as identified in the itemized statement and labeled on the invoice as "Multi-Axial Screw" with a cost per unit of \$703.00 at 4 units, for a total cost of \$2,812.00;
- "Cage cervical" as identified in the itemized statement and labeled on the invoice as "Calix-t " with a cost per unit of \$2,200.00;
- "Kit graft" as identified in the itemized statement and labeled on the invoice as "Kit Graft 10cc budled bone" with a cost per unit of \$2,931.00;
- "Fibrin sealant" as identified in the itemized statement was not supported by cost. No payment.
- "Matrix Regeneration" as identified in the itemized statement was not supported by cost. No payment.

Per DWC Rule 28 TAC §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 460. 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 is \$25,194.23. This amount multiplied by 108% results in a MAR of \$27,209.77.

The total net invoice amount (exclusive of rebates and discounts) supported by implant cost is \$8,343.00. 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 \$834.30. The total recommended reimbursement amount for the implantable items is \$9,177.30.

The total recommended payment for the services in dispute is \$36,387.07. This amount less the amount previously paid by the insurance carrier of \$35,654.71 leaves an amount due to the requestor of \$732.36. 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 Hartford Casualty Insurance Co must remit to Baylor Surgical Hospital \$732.46 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	May 5, 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.