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 Hospital

Respondent Name
Texas Municipal League Intergovernmental

MFDR Tracking Number
M4-23-1985-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
April 10, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 5, 2022	111-278	$13,320.75	$0.00
	Total	$13,320.75	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" addressed to the Texas Department of Insurance. Requests for reconsideration should be sent to the worker's compensation carrier not TDI. This document dated April 1, 2023 states, "The charges were not paid correctly per TX work comp fee schedule. According to TX work comp fee schedule the expected reimbursement for Inpatient stay is $29,737.91."

Amount in Dispute: $13,320.75

Respondent's Position

"The provider has requested additional reimbursement for implants in the amount of $13,320.75. However, no additional reimbursement is due. The supply house invoices totaled $2,6374.78 rather than the billed amount of $15,381.59. The carrier reimbursed the provider the amount of $3,599.01 for implants based on submitted supply house invoices."

Response Submitted by: Flahive, Ogden & Latson

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.404 sets out the acute care hospital fee guideline for inpatient services.

Denial Reasons

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

- 350 – Bill has been identified as a request for reconsideration or appeal
- 353 – This charge was reviewed according to the submitted invoice and documentation
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
- 468 – Reimbursement is based on the medical hospital inpatient prospective payment system methodology
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Did the requestor support the cost of the requested implants?

Findings

1. DWC Rule §134.404(g) states, "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 that the separate implantables requested include:

   - PLATE 3.5MM" as identified in the itemized statement with a cost per unit of $1,728.00; The requestor included a purchase order dated August 26, 2022. This is after the date of service of August 5, 2022. The cost of the implant is not supported. No separate reimbursement recommended.

- "SCREW BONE 3.5X 26" as identified in the itemized statemen. The requestor included a "Material Management Inquire" not a manufacturers invoice. The cost of the implant is not supported. No additional payment recommended.
- "SCREW BONE 3.5 X 32" as identified in the itemized statement. The requestor included a "Material Management Inquire" not a manufacturers invoice. The cost of the implant is not supported. No additional payment recommended.
- "SCREW BONE 3.5 X 42" as identified in the itemized statement. The requestor included a "Material Management Inquire" not a manufacturers invoice. The cost of the implant is not supported. No additional payment recommended.
- "SCREW BONE 30 X 3.5" as identified in the itemized statement. The requestor included a "Material Management Inquire" not a manufacturers invoice. The cost of the implant is not supported. No additional payment recommended.
- "SCREW BONE 3.5 X 32" as identified in the itemized statement. The requestor included a "Material Management Inquire" not a manufacturers invoice. The cost of the implant is not supported. No additional payment recommended.
- "SCREW BONE 34 X 3.5" as identified in the itemized statement. The requestor included a "Material Management Inquire" not a manufacturers invoice. The cost of the implant is not supported. No additional payment recommended.
- "SCREW BONE 3.5 X 38" as identified in the itemized statement. The requestor included a "Material Management Inquire" not a manufacturers invoice. The cost of the implant is not supported. No additional payment recommended.
- "SCREW BONE 3.5 X 30" as identified in the itemized statement. The requestor included a "Material Management Inquire" not a manufacturers invoice. The cost of the implant is not supported. No additional payment 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 not 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.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 23,2023 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.