



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Surgical Hospital

Respondent Name

City of Fort Worth

MFDR Tracking Number

M4-23-2837-01

Carrier's Austin Representative

Box Number 04

DWC Date Received

July 11, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 6, 2023	C1713	\$3,674.00	\$0.00
January 6, 2023	C1781	\$2,970.00	\$0.00
	Total	\$6,644.00	\$0.00

Requestor's Position

The requestor did not submit a position statement with this request for medical fee dispute resolution. They did submit a document titled "Reconsideration." Reconsideration requests must be sent to the workers' compensation carrier not the Texas Department of Insurance. This document states, "Per EOB received payment was disallowed for implants, and separate reimbursement was requested in Box 80 of UB-04 form for implants."

Amount in Dispute: \$6,644.00

Respondent's Position

"...Sedgwick and City of Fort Worth have reviewed the MDR Request and the bills in question. They received four submissions from the provider and none of EOBs indicated separate reimbursement for implants in box 80 as submitted to the state. The MDR Request only lists one implant invoice on page 31, however, there is more than one implant per pages 45 & 46. Since

implant invoices are required to price per state guidelines, Sedgwick is unable to process for additional payment based on the information provided.”

Response submitted by: Ricky D. Green, PLLC

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 §134.403](#) sets out the fee guidelines for outpatient hospital services.

Denial Reasons

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

- 97 – The benefit for this service is included in the payment/allowance for another service procedure that has already been adjudicated
- 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.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on the re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. What rule is applicable to reimbursement?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking payment of implants rendered as part of outpatient surgery rendered in January of 2023. The insurance carrier processed the fee at the Medicare facility specific rate multiplied by 200%. The requestor states separate reimbursement was requested on the original bill and invoices to support the cost were provided.

2. DWC Rule 28 TAC §134.403 (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 itemized statement found the following items listed under revenue code 278,

- "Staple Tendon Arthroscope" as identified in the itemized statement was not supported by invoice.
- "Anchors Bone 3 w/arthro" as identified in the itemized statement was not supported by invoice.
- "Suture anchor 4.75 x 14mm" as identified in the itemized statement was not supported by invoice.
- "Suture anchor swivelock" as identified in the itemized statement and labeled on the invoice as "DBL Loaded 55mm BC SWVLK" with a cost per unit of \$709.00; The itemized statement indicates two units however the "Implant Log" from the operative report only indicates one unit.
- "Suture anchor dbl loaded" as identified in the itemized statement was not supported by invoice.
- "Implant mesh bioinductive" as identified in the itemized statement was not supported by invoice.

The total net invoice amount (exclusive of rebates and discounts) is \$709.00. 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 \$70.90. The total recommended reimbursement amount for the implantable items is \$779.90.

The payable procedure code 29827 has status indicator J1, for procedures paid at a comprehensive rate. procedure.

This code is assigned APC 5114. The OPSS Addendum A rate is \$6,614.63 multiplied by 60% for an unadjusted labor amount of \$3,968.78, in turn multiplied by facility wage index 0.9562 for an adjusted labor amount of \$3,794.95.

The non-labor portion is 40% of the APC rate, or \$2,645.85.

The sum of the labor and non-labor portions is \$6,440.80.

The Medicare facility specific amount is \$6,440.80 multiplied by 130% for a MAR of \$8,373.04.

The total recommended reimbursement for the disputed services is \$9,152.94. The insurance carrier paid \$12,881.60. Additional payment is not 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 entitled to \$0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

August 3, 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 electrónico CompConnection@tdi.texas.gov.