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
City of Fort Worth

MFDR Tracking Number
M4-23-2909-01

Carrier's Austin Representative
Box Number 4

DWC Date Received
July 17, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 25, 2022	C1713	$11,439.95	$0.00
August 25, 2022	C1792	$1050.50	$0.00
August 25, 2022	C9359	$4,840.00	$0.00
	Total	$17,330.45	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. Rather, they submitted a document titled "Reconsideration" addressed to Texas Department of Insurance. Requests for reconsideration must be sent to the workers' compensation insurance carrier not TDI. This document states, "The charges were not paid correctly per TX workers compensation fee schedule. Please note that implants should be reimbursed at manual cost plus 10%, and implant invoices are enclosed for review."

Supplemental response dated August 22, 2023.

"Payment of $8,752.09 has been received with a remaining balance of $360.53. Please continue with dispute."

Amount in Dispute: $17,330.45

Respondent's Position

"The City of For Worth has reprocessed this bill and issued additional payment on ICN#7904-9911829 in the amount of $8,752.09. The amount listed in the MDR lists a total of $33,622.20 however, after adding their allowances, it totals $33,261.67. After adjustments of $24,509.58 the amount due is $8,752.09."

Response submitted by: Ricky D Green

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:

- W3 – Additional payment made on appeal/reconsideration.
- 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.

Issues

1. Did the requestor support cost of implants?
2. What rule is applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of implants rendered as part of an outpatient hospital surgery in August of 2022. The respondent acknowledged receipt of a payment in the amount of $8,752.09 but wished to continue with the request for MFDR for a balance of $360.53.

2. DWC Rule 28 TAC §134.403 (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 found for item identified as "Infuse Kit Bone Graft" on the itemized bill was not supported by an invoice. The invoice submitted was dated October 19, after the date of service August 25, 2022. This item will not be considered in this review.

   The item identified as "Trinity Elite 5cc Med" on the itemized bill was not supported by an invoice. The submitted invoice was dated October 27, 2022 after the August 25, 2022 date of service. This item will not be considered in this review.

3. Review of the remaining items billed under Revenue Code is as follows.

   - "Head Tulip 30mm" as identified in the itemized statement and labeled on the invoice as "Creo Mis Tulip 30mm" with a cost per unit of $500.00 at 4 units, for a total cost of $2,000.00;
   - "Cap Locking Mis Creo" as identified in the itemized statement and labeled on the invoice as "Creo Locking Cap" with a cost per unit of $75.00 at 4 units, for a total cost of $300.00;
   - "Screw Creo one 7.5" as identified in the itemized statement and labeled on the invoice as "Creo 7.5 x 50mm" with a cost per unit of $825.00 at 2 units, for a total cost of $1,650.00;
   - "Screw 7.5 x 45mm" as identified in the itemized statement and labeled on the invoice as "Creo 7.5 x 45mm" with a cost per unit of $825.00 at 2 units, for a total cost of $1,650.00;
   - "Spacer Rise 10x26mm" as identified in the itemized statement and labeled on the invoice as "15mm Rise spacer" with a cost per unit of $4,300.00;
   - "Rod Creo Mis" as identified in the itemized statement and labeled on the invoice as "Rod" with a cost per unit of $250.00 at 2 units, for a total cost of $500.00;

   The total net invoice amount (exclusive of rebates and discounts) is $10,400.00. 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 $1,040.00. The total recommended reimbursement amount for the implantable items is $11,440.00.

4. The total recommended reimbursement for the disputed services is $27,381.04 (procedure code 22633 has a MAR of $15,941.04 plus the supported implant allowance of $11,440.00.)

   The insurance carrier paid $33,261.67. Additional payment is not recommended.

<u>Conclusion</u>

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

		August 31, 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 electronico CompConnection@tdi.texas.gov.