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
M4-24-0777-01

Carrier's Austin Representative
Box Number 4

DWC Date Received
December 6, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 24, 2023	C1713	$6,640.13	$0.00
May 24, 2023	C1781	$3,118.50	$0.00
	Total	$9,758.63	$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" dated September 28, 2023, that states, "According to TX Workers Compensation fee schedule the expected reimbursement for DOS 5/24/2023 is $18,141.67. Please note that separate reimbursement was requested in Box 80 of UB-04 form for implants, and implants invoices are enclosed for review. Per Rule 134.402, implants should be reimbursed at manual cost plus 10%."

Amount in Dispute: $9,758.63

Respondent's Position

"Since the City has made full payment when it issued additional payment for $5,250.07 under check number 129082, the City of has paid Baylor Surgical Hospital the full amount owed under state fee guideless[sic]."

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 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.
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- W3 – Additional payment made on appeal/reconsideration.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What rule is applicable to reimbursement of implants rendered during outpatient surgery?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for implants rendered during an outpatient hospital surgical procedure in May 2023. The respondent states in their position statement, "…Since the City has made full payment when it issued additional payment for $5,250.07 under check

number 129082, the City of has paid Baylor Surgical Hospital the full amount owed under state fee guideless[sic].

DWC Rule 28 TAC §134.403(g) 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.

The following items were submitted on the medical bill and identified on the itemized statement under Revenue Code 278.

- "Staple Tendon Arthroscope" as identified in the itemized statement and labeled on the invoice as "Tendon Anchors 8" with a cost per unit of $367.50 at 2 units, for a total cost of $735.00;
- "Anchors Bone 3 w arthro" as identified in the itemized statement and labeled on the invoice as "Bone Anchors 3 w arthro Del Sys" with a cost per unit of $682.50;
- "Implant Bioasorbable " as identified in the itemized statement and labeled on the invoice as "Implant Bioasorbable Speedridge" with a cost per unit of $3,184.00;
- "Lasso Sut Crescent Quick" as identified in the itemized statement and labeled on the invoice as "Crescent, Quickpass Lasso" with a cost per unit of $160.00;
- "Suture Anchor Swivelock" as identified in the itemized statement and labeled on the invoice as "DBL Loaded 4.75mm bc swvlk" with a cost per unit of $425.00 at 3 units, for a total cost of $1,275.00;
- "Implant Mesh Bioinductive" as identified in the itemized statement and labeled on the invoice as "Bioinductive implant w/arth Del Lrt" with a cost per unit of $2,835.00.

The total net invoice amount (exclusive of rebates and discounts) is $8,871.50. 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 $887.15. The total recommended reimbursement amount for the implantable items is $9,758.65.

The total recommended reimbursement for the disputed services is $18,131.69. The insurance carrier made two payments the first in the amount of $12,881.60 dated July 13, 2023 via EFT number 123269 and the second in the amount of $5,250.09 on December 19, 2023 via check number 129082 for a total payment of $18,131.69. 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	January 2, 2024 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.