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
M4-24-0960-01

Carrier's Austin Representative
Box Number 4

DWC Date Received
January 3, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 13, 2023	111-278	$12,760.87	$1,518.71
	Total	$12,760.87	$1,518.71

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" dated December 27, 2023 that states, "According to TX Workers Compensation guidelines the expected reimbursement for DOS 3/13/2023 is $64.339.53. Per TX Rule 134.402, implants should be reimbursed at manual cost plus 10%, which the expected reimbursement for Rev code 278 is $21,675.46. Per the IPPS Pricer, DRG code 454 should be paid at $39,503.77 x 108% =42,664.07.

Amount in Dispute: $12,760.87

Respondent's Position

"Ms. Williams asserts on the DWC060 Form, received on 01/03/2024, that the "Amount Billed" For Treatment Codes in Dispute 111-278 is $21,675.46. The amount billed for Revenue Code 278 is $19,705.00 and payments were made which total $16,312.30. Upon review of the invoices, it appears that the provider billed at cost and is now expecting above what they billed. This makes no logical sense. Petitioner is asserting that payment is due for more than what was charged for

the implants. After review of the invoices, payment recommendations were made to pay the full amount charged for the implants ($17,750.00), except for the stem cell item. Payment was denied for a stem cell product with is deemed experimental by the FDA (see attached documents) and prior authorization for use of this product was not obtained."

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 (TAC) §134.404 sets out the acute care hospital fee guideline for inpatient services.
2. 28 TAC §133.240 sets out the requirements of medical payment and denials.
3. 28 TAC §19.U sets out requirements of utilization review.
4. 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:

- 10 – Upon review of submitted request for reconsideration, ForeSight has determined that no additional allowance will be made.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- 91 – The item billed has determined to be non-reimbursable.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – Additional payment made on appeal/reconsideration.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 947 – Upheld. No additional allowance has been recommended.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Bill is a reconsideration or appeal.
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.

- 2008 – Additional payment made on appeal/reconsideration.
- 4(illegible) – Payment made per Medicare's IPPS methodology, with the applicable state markup.
- 5191 – This amount has been determined to have been paid in excess of the correct allowance, therefore an overpayment request is being issued.
- 6981 – Charges for surgical implants are reviewed separately by ForeSight Medical, Please expect a detailed explanation of review for surgical implant charges directly from ForeSight Medical and direct all surgical implant inquires to ForeSight Medical…

Issues

1. Is Foresights' position statement regarding implant being non-covered supported?

2. Is Foresights' application of reimbursement of the implants per applicable fee guideline?

3. Is Baylor Surgical Hospital of Fort Worth entitled to additional reimbursement?

Findings

1. The respondent states in their position statement, "Payment was denied for a stem cell product with is deemed experimental by the FDA… …and prior authorization for use of the product was not obtained."

   DWC Rule 28 Texas Administrative Code §133.240 (q) states, in relevant part, "When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title … Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title …, including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor …"

   Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003 (b)(31) or §133.240 (q).

   Therefore, the insurance carrier did not appropriately raise appropriateness for this dispute and this denial reason will not be considered in this review.

2. The insurance carrier indicates in their position statement, "After review of the invoices, payment recommendations were made to pay the full amount charged for the implants ($17,500)…

   DWC Rule 28 Texas Administrative Code §134.404(e)(2) states in pertinent parts, "…**regardless of billed amount**, reimbursement shall be: if not contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.

   DWC Rule 28 Texas Administrative Code §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 manufacturers' 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 respondents position that reimbursement is based on charged amount is not supported. The applicable fee guidelines are shown below.

3. 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 http://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).

   Per §134.404(f)(1)(B), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 108%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 454. The services were provided at Baylor Surgical Hospital of Fort Worth. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $30,503.77. This amount multiplied by 108% results in a MAR of $42,664.07.

   Additionally, the provider requested separate reimbursement of implantables.

   Review of the submitted documentation finds that the separate implantables include:

   - "Hedron IA Spacer" as identified in the itemized statement with a cost per unit of $5,500.00; ;
   - "Cap Locking Mis Creo" as identified in the itemized statement with a cost per unit of $75.00 at 4 units, for a total cost of $300.00;
   - "Head Tulip 30mm Creo Mis" as identified in the itemized statement with a cost per unit of $500.00 at 4 units, for a total cost of $2,000.00;
   - "Screw 7.5 x 45mm Robotic" as identified in the itemized statement with a cost per unit of $825.00 at 3 units, for a total cost of $2,475.00;
   - "Screw Creo One 7.5 x 50m" as identified in the itemized statement with a cost per unit of $825.00;
   - "Rod Creo Mis 5.5mm Curve" as identified in the itemized statement with a cost per unit of $250.00 at 2 units, for a total cost of $500.00;
   - "Anchor Indy 25mm" as identified in the itemized statement with a cost per unit of $175.00;
   - "Screw 22mm Single Buttress" as identified in the itemized statement with a cost per unit of $500.00;

- "Screw 5.5mm x 26 mm Buttress" as identified in the itemized statement with a cost per unit of $150.00;
- "Graft Kit Bone 7510050" as identified in the itemized statement with a cost per unit of $955.00;
- "Trinity Elite 5cc Med" as identified in the itemized statement with a cost per unit of $1,955.00;
- "Sheet versawrap" as identified in the itemized statement. Review of the submitted documentation found insufficient evidence to support the cost of this item. No reimbursement can be recommended.
- "Implant FiberFuse DBM" as identified in the itemized statement with a cost per unit of $875.00. .

The total net invoice amount (exclusive of rebates and discounts) is $16,210.00. 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 $1,621.00. The total recommended reimbursement amount for the implantable items is $17,831.00.

The total recommended payment for the services in dispute is $60,495.07. This amount less the amount previously paid by the insurance carrier of $58,976.36 leaves an amount due to the requestor of $1,518.71. 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 City of Fort Worth must remit to Baylor Surgical Hospital $1,518.71 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 6, 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.