



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Surgical Hospital

Respondent Name

City of Fort Worth

MFDR Tracking Number

M4-24-0914-01

Carrier's Austin Representative

Box Number 4

DWC Date Received

December 27, 2023

Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| July 24, 2023 | 111-278 | \$6,489.84 | \$0.00 |
| Total | | \$6,489.84 | \$0.00 |

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. A review of a document titled "Reconsideration" dated December 18, 2023, states, "According to TX Workers Compensation guidelines the expected reimbursement for DOS 7/24/2023 is \$48,408.82. Per TX Rule 134.402, implants should be reimbursed at manual cost plus 10%. Implant invoices are enclosed for review. Previous payment received totaled \$44,406.56."

Supplemental response February 26, 2024.

"Provider received a partial payment of \$141.16, still pending remaining balance of \$3,861.10."

Amount in Dispute: \$6,489.84

Respondent's Position

"The City of Fort Worth does not owe any additional payment for the requested services for the following reasons. They City has been paying for the implants as requested but the provider failed to separate the request for reimbursement on submission. When the request for reconsideration was received indicating separate reimbursement the City allowed additional payment on the implants, however, that created an overpayment on the other services, which allowed a reimbursement factor of 108%. Once the adjustment was calculated it was determined that an additional \$141.16 was payable to the Requestor."

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 Texas Administrative Code \(TAC\) §134.404](#) sets out the acute care hospital fee guideline for inpatient services.
2. [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:

- 1002 – Due to an error in processing the original bill, we are recommending further payment be made for the above noted procedure.
- 1003 – In response to your appeal of our previous re-evaluation, no significant additional documentation or information regarding this claim has been received. Our position remains unchanged on the same questions that were previously posed by the provider. Therefore, no additional allowance is recommended.
- 2005 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/ RECONSIDERATION.
- 2008 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- 4896 – 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.
- P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- P13 – Payment reduced or denied based on Workers' Compensation jurisdictional regulations or payment policies.
- 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.

Issues

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

Findings

1. This dispute regards inpatient hospital facility services rendered in July of 2023. The insurance carrier issued a payment in the amount of \$8,381.14 and reduced the remaining billed amount based on the workers compensation jurisdictional fee schedule. These disputed services are 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>. A review of the submitted documentation finds that the DRG code assigned to the services in dispute is 455. 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 \$31,053.54. This amount multiplied by 108% results in a MAR of \$33,537.82.

Additionally, the provider requested separate reimbursement of implantables. Per §134.404(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.

A review of the submitted documentation finds that the separate implantables include:

- "Screw 22mm single buttress" as identified in the itemized statement and labeled on the invoice as "22mm Single Screw Buttress Plate" with a cost per unit of \$500.00;
- "Screw 5.5mm x 24mm buttress" as identified in the itemized statement and labeled on the invoice as "5.5mm x 24mm Buttress Plate Screw" with a cost per unit of \$150.00;
- "CAP locking mis creo" as identified in the itemized statement and labeled on the

invoice as "CREO MIS Locking cap" with a cost per unit of \$50.00 at 4 units, for a total cost of \$200.00;

- "Head Tulip 30mm creo mis" as identified in the itemized statement and labeled on the invoice as "CREO MIS Mod Polyaxial Tulip, 30mm" with a cost per unit of \$375.00 at 2 units, for a total cost of \$750.00.
- "Screw 7.5 x 45mm Robotic" as identified in the itemized statement and labeled on the invoice as "CREO ONE 7.5x45mm Robotic, HA modular" with a cost per unit of \$825.00 at 2 units, for a total cost of \$1,650.00.
- "Rod Creo Mis 5.5mm Curve" as identified in the itemized statement and labeled on the invoice as "CREO MIS 5.5mm Curved Rod, Titanium Alloy" with a cost per unit of \$175.00.
- "Rod Creo Mis 5.5mm Curve" as identified in the itemized statement and labeled on the invoice as "CREO MIS 5.5mm Curved Rod, Titanium Alloy" with a cost per unit of \$175.00.
- "Anchor Indy 25mm" as identified in the itemized statement and labeled on the invoice as "Lumbar Anchor 25mm" with a cost per unit of \$150.00;
- "Implant Single Head Open" as identified in the itemized statement and labeled on the invoice as "Single Head Open Lateral Connector, 5.5-6.0" with a cost per unit of \$392.00 at 2 units, for a total cost of \$784.00.
- "Hedron IA Spacer 29x39" as identified in the itemized statement and labeled on the invoice as "HEDRON IA Spacer 29x39,15mm" with a cost per unit of \$5,200.00;
- "Graft Kit Bone 7510050" as identified in the itemized statement. Insufficient evidence (invoice) was found to support the cost of the disputed item. No payment is recommended.
- "Trinity Elite 5cc Med" as identified in the itemized statement. Insufficient evidence (invoice) was found to support the cost of the disputed item. No payment is recommended.
- "Implant Fiberfuse DBM 5c" as identified in the itemized statement. Insufficient evidence (invoice) was found to support the cost of the disputed item. No payment is recommended.

The total net invoice amount (exclusive of rebates and discounts) is \$9734.00. 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 \$973.40. The total recommended reimbursement amount for the implantable items is \$10,707.40.

2. The total recommended payment for the services in dispute is \$44,245.22. The insurance carrier issued payments totaling \$44,547.72, as a result, no additional reimbursement 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 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

March 5, 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 electrónico CompConnection@tdi.texas.gov.