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
M4-24-2379-01

Carrier's Austin Representative
Box Number 4

DWC Date Received
June 26, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 2, 2023	111-278	$5,900.17	$0.00
	Total	$5,900.17	$0.00

Requestor's Position

The requestor did not include a position statement with this request for MFDR. They did submit a document titled "Reconsideration" that states UHS contacted Foresight Medical and was advised that an additional $6,659.50 was recommended, and provider has not received additional payment. Please reprocess and remit payment for remaining balance due."

Amount in Dispute: $5,900.17

Respondent's Position

"The City of Fort Worth and Sedgwick have reviewed the MDR and do not find any additional payment is due. The original bill submitted by the provider did not indicate that implants were to be priced separately and the bill was originally processed at 143% Medicare IPPS. The provider then submitted a request for reconsideration indicating separate reimbursement for implants. When bill was reprocessed, and the non-implant lines and the implant line was priced by our implant vendor at $6,659.50. The total payable would be $39,728.25 which is less than

the payment initially processed in the amount of $43,785.47. To date, no overpayment has been recouped."

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:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 4898 – Payment made per Medicare's IPPS methodology, with the applicable state markup.

Foresight

- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.

Issues

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

Findings

1. 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 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 $30,618,32. This amount multiplied by 108% results in a MAR of $33,068.87.

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.

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

- Head Tulip 30mm Creo Mis, quantity 4 billed amount $1500.00. No invoice submitted to support reported cost.
- Screw 22mm single Buttress, quantity 1 billed amount $500.00. Submitted documentation includes invoice to support cost of $500.00.
- Screw 5.5mm x 26mm Buttress, quantity 1 billed amount $150.00. Submitted documentation includes invoice to support cost of $150.00.
- Anchor Indy, quantity 1 billed amount $150.00. No invoice submitted to supported reported cost.
- Spacer Hedron IA 15 Deg, quantity 1 billed amount $5200.00. No invoice submitted to support reported cost.
- Cap locking Mis Creo, quantity 4 billed amount $200.00. No invoice submitted to support reported cost.
- Screw 7.5 x 40mm robotic, quantity 2 billed amount $1650.00. No invoice submitted to support reported cost.
- Screw Creo one 7.5 x 50m, quantity 2 billed amount $1650.00. No invoice submitted to support reported cost.
- Rod Creo Mis 5.5mm curve, quantity 2 billed amount $350.00. No invoice submitted to support reported cost.

- Graft Kit Bone 7510050, quantity 1, billed amount $955.00. No invoice submitted to support reported cost.
- Trinity Elite 5cc med, quantity 1, billed amount $1955.00. No invoice submitted to support reported cost.
- Implant Fiberfuse DBM, quantity 1, billed amount $875.00. No invoice submitted to support reported cost.

The total net invoice amount (exclusive of rebates and discounts) is $650.00. 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 $65.00. The total recommended reimbursement amount for the implantable items is $715.00.

2. The total recommended payment for the inpatient services and implants supported by invoices is $33,783.87. The insurance carrier paid $43,785.47. No additional payment 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	July 24, 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.