



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Surgical Hospital at
Trophy Club

Respondent Name

LM Insurance Corp

MFDR Tracking Number

M4-24-2993-01

Carrier's Austin Representative

Box Number 60

DWC Date Received

August 27, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 29, 2023	DRG 460	\$26,591.51	\$0.00
December 29, 2023	111-278	\$43,577.92	\$2,000.01
Total		\$70,169.43	\$2,000.01

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" dated July 3, 2024 that states, "Per EOB received bill denied due to provider out of network. Please note that authorization was obtained for treatment under Review# 291935, and proof of authorization enclosed for review."

Amount in Dispute: \$70,169.43

Respondent's Position

"As noted in the EOB released by the Carrier on 08/01/24 payment was issued in the amount of \$65,947.50. As shown on the EOB payment of DRG 460 was \$26,591.40 and REV 278 was in the amount of \$39,356.00... Implants were paid at \$39,356.00... as the provider only billed \$39,356.00 on the line. No additional payment is due."

Response Submitted by: Liberty Mutual

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:

- 4896 – Payment made per Medicare's IPPS methodology, with the applicable state markup.
- 11 – The recommended allowance for the supply was based on the attached invoice.
- 305 – The charge for this procedure, material, and or service is not normally billed. For Texas Jurisdiction Claims only.
- 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?
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%.

Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 460. The services were provided at Baylor Surgical Hospital at Trophy Club. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is \$24,621.77. This amount multiplied by 108% results in a MAR of \$26,621.77.

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:

- "INTERBODY ALIGN TI ALIF" as identified in the itemized statement and labeled on the invoice as "Align Ti ALIF Interbody 32 x 21 x 11" with a cost per unit of \$8,050.00.
- "ALIGH TI ALIF INTERBODY" as identified in the itemized statement and labeled on the invoice as "Align TI ALIF Interbody 36 x 26 x 13" with a cost per unit of \$8,050.00.
- "SCREW ACUITY SET ATS-T3" as identified in the itemized statement and labeled on the invoice as "set Screw" with a cost per unit of \$345.00 at 4 units, for a total cost of \$1,380.00;
- "PLATE A LINK COVER 11-14" as identified in the itemized statement and labeled on the invoice as "Align Break off Coverplate Assembly" with a cost per unit of \$340.00 at 2 units, for a total cost of \$680.00;
- "SCREW Z 5.0 X 20 MM" as identified in the itemized statement and labeled on the invoice as "A link Z Screw 5.0mm x 20mm T20" with a cost per unit of \$781.00 at 4 units, for a total cost of \$3,124.00;
- "SCREW ASTRA TI MIS 6.5MM" as identified in the itemized statement and labeled on the invoice as "Avant Ti MIS Poly Screw 6.50 x 50mm" with a cost per unit of \$1,306.00 at 2 units, for a total cost of \$2,612.00;
- "K-WIRE 1.5MM" as identified in the itemized statement and labeled on the invoice as "Nitinol Blunt tip guidewire" insufficient evidence to support this item was implanted. No separate reimbursement recommended. ;
- "SCREW A LINK Z 5.0MM" as identified in the itemized statement and labeled on the invoice as "A link Z Screw 5.0mm x 25mm T20" with a cost per unit of \$781.00 at 4 units, for a total cost of \$3,124.00;
- "SCREW POLY EXTENDED MIS" as identified in the itemized statement and labeled on the invoice as "Avant Ti MIS Poly Screw 7.50 x 45mm" with a cost per unit of \$1,306.00 at 2 units, for a total cost of \$2,612.00;

- "ROD 75MM X 5.5MM" as identified in the itemized statement and labeled on the invoice as "MIS Fixed Lordosed Rod 5.5 x 75mm" with a cost per unit of \$212.00 at 2 units, for a total cost of \$424.00;
- "ALLOGRAFT ACUPAC ADVANCE" as identified in the itemized statement and labeled on the invoice as "AcuPac PLUS 10cc" with a cost per unit of \$3,100.00 at 3 units, for a total cost of \$9,300.00.

The total net invoice amount (exclusive of rebates and discounts) is \$39,356.00. 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 \$2,000.00. The total recommended reimbursement amount for the implantable items is \$41,356.00.

The respondent states, "Implants were paid at \$39,346.00... ..as the provider only billed \$39,356.99." DWC Rule 28 TAC 134.404(e) states, "Except as provided in subsection (h) of this section, **regardless of billed amount**, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no 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.

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

2. The total recommended payment for the services in dispute is \$67,947.51. This amount less the amount previously paid by the insurance carrier of \$65,947.50 leaves an amount due to the requestor of \$2,000.01. 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 Liberty Mutual must remit to Baylor Surgical Hospital at Trophy Club \$2,000.01 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

September 19, 2024

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 electrónico CompConnection@tdi.texas.gov.