



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Baylor Orthopedic & Spine Hospital

**Respondent Name**

TASB Risk Management Fund

**MFDR Tracking Number**

M4-25-0071-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

September 9, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 24, 2024	111-278	\$4,573.92	\$4,460.29

### Requestor's Position

"According to TX Workers Compensation guidelines the expected reimbursement for DOS 5/24/2024 is \$23,922.41. Please note that Rev code 278/Implants were underpaid and should be reimbursed at manual cost plus 10%..."

Rev code 278-UB TX O/P: Implants@ Manual cost + 10%=\$9,102.50."

**Amount in Dispute:** \$4,573.92

### Respondent's Position

"Per the additional documentation received we stand on previous payment of \$23,922.41 under bill TSTX-... as full payment."

**Response Submitted by:** TASB Risk Management Fund

## 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 \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.404](#) sets out the acute care hospital fee guideline for inpatient services.

### Adjustment Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 305 - THE IMPLANT IS INCLUDED IN THIS BILLING AND IS REIMBURSED AT THE HIGHER PERCENTAGE CALCULATION.
- 350 - BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 351 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
- 468 - PRICING IS BASED ON THE MEDICAL HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM METHODOLOGY.
- P12 – WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- P13 - PAYMENT REDUCED OR DENIED BASED ON WORKERS' COMPENSATION JURISDICTIONAL REGULATIONS OR PAYMENT POLICIES, USE ONLY IF NO OTHER CODE IS APPLICABLE.
- U03 -THE BILLED SERVICE WAS REVIEWED BY UR AND AUTHORIZED.
- W3 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

### Issues

1. What services are in dispute?
2. What rules apply to the reimbursement of the services in dispute?
3. Is the requestor entitled to additional reimbursement?

## Findings

1. A review of the DWC060 Medical Fee Dispute Resolution (MFDR) Request form and the requestor's position statement finds that the requestor is seeking additional reimbursement for implants billed under revenue code 278 only. Therefore, DWC will review and adjudicate this MFDR request in accordance with the applicable statutes and rules.
2. This dispute involves inpatient hospital facility services in which separate reimbursement for implantable items was requested on the medical bill.

DWC finds that 28 TAC §134.404(g) applies to the reimbursement of the services in dispute, stating, "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."

3. The requestor is seeking additional reimbursement in the amount of \$4,573.92 for surgical implantable items provided to an injured employee in an inpatient hospital facility.

A review of the submitted itemized statement finds that the separate implantable items in dispute are:

- screw fixed locking 4.75 at \$70.00 per unit x 3 units = \$210.00 total cost
- screw comprehensive central hex at \$70.00 per unit x 1 unit = \$70.00 total cost
- screw fixed locking 3.5 at \$70.00 per unit x 1 unit = \$70.00 total cost
- system shoulder 25mm Mini B at \$1,500.00 per unit x 1 units = \$1,500.00 total cost
- prosthesis shoulder 36MM Glen at \$1,025.00 per unit x 1 units = \$1,025.00 total cost
- stem humeral 12MM x 122MM at \$2,700.00 per unit x 1 units = \$2,700.00 total cost
- bearing HMRL 36MM std at \$1,450.00 per unit x 1 units = \$1,450.00 total cost
- humeral tray plus 5MM at \$1,250.00 per unit x 1 units = \$1,250.00 total cost

The total net implantable invoice amount (exclusive of rebates and discounts) is \$8,275.00.

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-ons per admission, is \$827.50.

The total recommended reimbursement amount for the implantable items in dispute is \$9,102.50 in accordance with 28 TAC §134.404(g).

The insurance carrier previously paid \$4,642.21 for the implantable items in dispute.

DWC finds that the requestor is entitled to additional reimbursement in the amount of \$4,460.29 for implantable items billed under Revenue code 278 on disputed date of service May 24, 2024.

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 requestor has established that additional reimbursement in the amount of \$4,460.29 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 TASB Risk Management Fund must remit to Baylor Orthopedic & Spine Hospital \$4,460.29 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

		October 31, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).