



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Orthopedic & Spine Hospital

Respondent Name

Grand Prairie ISD

MFDR Tracking Number

M4-25-1107-01

Carrier's Austin Representative

Box Number 44

DWC Date Received

January 24, 2025

Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| February 6, 2024 | 111-278 | \$909.99 | \$909.99 |
| Total | | \$909.99 | \$909.99 |

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of a document titled "Reconsideration" that states, "Per EOB received, the implants were underpaid. Implants should be reimbursed at manual cost plus 10%."

Amount in Dispute: \$909.99

Respondent's Position

"The provider was reimbursed in full for the billed charge amount of \$9,100.00 for the implants but is now asserting a payment is due in excess of the amount charged. ...Provider correctly states that they are entitled to 'the provider's cost + 10%' but erroneously misinterprets the statute and is claiming the amount due is the actual charge of \$9,100.00 + 10%, not the cost + 10%. Provider is asserting a balance due of more than what was charged."

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 \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.403](#) sets out the reimbursement guidelines for implants rendered during an outpatient hospital surgical procedure.

Denial Reasons

- 10 – Upon review of submitted request for reconsideration, ForeSight has determined that no additional allowance will be made.
- 6 – Payment was based on published state regulations and in accordance with documentation provided by your facility.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.

Issues

1. Is the respondent's position supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states in their position statement, "Provider is asserting a balance due of more than what was charged." DWC Rule 28 TAC §134.403 (e) (2) states in pertinent part, "**Regardless of billed amount**, reimbursement shall be:

(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**.

DWC Rule 134.403 (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 **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

2. The requestor is seeking payment of the following items billed under Revenue Code 278.

| Name from itemized statement | Name from invoice | Implantable billed price | Cost/unit | # Units | Total cost | 10% not to exceed \$1000 | Total allowed per implantable |
|------------------------------|------------------------------------|--------------------------|------------|---------|------------|--------------------------|-------------------------------|
| Cap Price Screw Bone 5.0 | Cap Price Screw Bone | \$50.00 | \$50.00 | 1 | \$50.00 | \$5.00 | \$55.00 |
| Cap Price Screw Bone 5.0 | Cap Price Screw Bone | \$50.00 | \$50.00 | 1 | \$50.00 | \$5.00 | \$55.00 |
| Cap Price Screw Bone 22m | Cap Price Screw Bone | \$50.00 | \$50.00 | 1 | \$50.00 | \$5.00 | \$55.00 |
| Screw 6.5 x 35 central | Screw 6.5 35 central | \$350.00 | \$350.00 | 1 | \$350.00 | \$35.00 | \$385.00 |
| Insert Reversed 39mm x 9 | Insert Reversed 39 mm | \$1,000.00 | \$1,000.00 | 1 | \$1,000.00 | \$100.00 | \$1,100.00 |
| Baseplate Reversed Sta | Baseplate Reversed Lateralized 3mm | \$2,200.00 | \$2,200.00 | 1 | \$2,200.00 | \$220.00 | \$2,420.00 |
| Glenosphere Reversed Sta | Glenosphere Reversed Standard 39mm | \$1,800.00 | \$1,800.00 | 1 | \$1,800.00 | \$180.00 | \$1,980.00 |
| Stem humeral standard | Stem Humeral Standard | \$2,700.00 | \$2,700.00 | 1 | \$2,700.00 | \$270.00 | \$2,970.00 |
| Tray reversed shoulder | Tray Reversed Shoulder | \$900.00 | \$900.00 | 1 | \$900.00 | \$90.00 | \$990.00 |
| | | \$9,100.00 | \$9,100.00 | 9 | \$9,100.00 | \$910.00 | \$10,010.00 |

The total net invoice amount (exclusive of rebates and discounts) is \$9,100.00. 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 \$910.00. The total recommended reimbursement amount for the implantable items is \$10,010.00.

3. The total recommended reimbursement for the disputed services is \$10,010.00. The insurance carrier paid \$9,100.00. The requestor is seeking \$909.99, 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 requestor 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 Grand Prairie ISD must remit to Baylor Orthopedic & Spine Hospital \$909.99 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 27, 2025

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.