



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Baylor Surgical Hospital at Trophy Club

**Respondent Name**

American Zurich Insurance Co

**MFDR Tracking Number**

M4-25-1865-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

April 14, 2025

### Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| June 26, 2024    | 111-278           | \$7,760.12        | \$0.00     |
| <b>Total</b>     |                   | \$0.00            | \$0.00     |

### Requestor's Position

The requestor submitted a document titled "Reconsideration" dated April 4, 2025 that states, "The billed charges were not paid correctly per TX work comp guidelines. In accordance to the worker compensation guidelines the invoice should be processed and paid per the IPPS Pricer Calculations for the DRG times 108%. Also, implants should be reimbursed at manual code plus 10."

**Amount in Dispute:** \$7,760.12

### Respondent's Position

"We are attached the carrier's calculation to explain how it arrived at the total reimbursement amount of \$93,405.11. We are also attaching an EOB dated May 1, 2025 that recommends payment of \$732.28 in interest. The provider is not entitled to any additional reimbursement."

## **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.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 18 – Exact duplicate claim/service

### 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](http://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 454. The services were provided at Baylor Medical Center at Trophy Club. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is \$41,169.55. This amount multiplied by 108% results in a MAR of \$44,463.11.

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:

- "Allograft Acupac Advance" as identified in the itemized statement and labeled on the invoice as "AcuPac 25cc" with a cost per unit of \$6,200.00 at 2 units, for a total cost of \$12,400.00;
- "Interbody Align TI Alif" as identified in the itemized statement and labeled on the invoice as "Align TI ALIF Interbody" with a cost per unit of \$8,050.00;
- "Interbody Align TI Alif" as identified in the itemized statement and labeled on the invoice as "Align TI ALIF Interbody" with a cost per unit of \$8,050.00;
- "Interbody Align TI Alif" as identified in the itemized statement and labeled on the invoice as "Align TI ALIF Interbody" with a cost per unit of \$8,050.00;
- "Screw Align Alif 5.0 mm" as identified in the itemized statement and labeled on the invoice as "Align ALIF Screw 5 x 25" with a cost per unit of \$1,562.00 at 5 units, for a total cost of \$7,810.00;
- "Screw a link Z 5.0 x 25m" as identified in the itemized statement and labeled on the invoice as "Align ALIF Screw 5 x 25" with a cost per unit of \$781.00 at 2 units, for a total cost of \$1,562.00;
- "Plate A Link Cover" as identified in the itemized statement and labeled on the invoice as "Align Break off Coverplate" with a cost per unit of \$340.00 at 3 units, for a total cost of \$1,020.00;
- "Rod 5.5mm x 100 mm" as identified in the itemized statement no invoice was found to allow the reimbursement calculation. Recommended reimbursement is \$0.00.
- "Screw set T-30" as identified in the itemized statement no invoice was found to allow the reimbursement calculation. Recommended reimbursement is \$0.00
- "Screw 7.0mm x 40mm" as identified in the itemized statement no invoice was found to allow the reimbursement calculation. Recommended reimbursement is \$0.00
- "Screw TI poly 7.00mm x 45" as identified in the itemized statement no invoice was

found to allow the reimbursement calculation. Recommended reimbursement is \$0.00

The total net invoice amount (exclusive of rebates and discounts) supported by manufacturer's invoice is \$46,942.00. 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 \$48,942.00.

2. The total recommended payment for the services in dispute is \$93,405.11. The respondent supports payment made in the amount of \$93,405.11. 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 requestor 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

\_\_\_\_\_  
May 15, 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](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).