TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Surgical Hospital

Respondent Name
Charter Oak Fire Insurance Co

MFDR Tracking Number
M4-23-3321-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
August 28, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 24, 2023	C1713	$9313.70	$0.00
April 24, 2023	29827	$0.00	$0.00
	Total	$4524.73	$0.00

Requestor's Position

"The attached claim was processed and paid incorrectly. Please recalculate the fee schedule allowed amounts on all surgical procedures making sure to use the correct national rate and the wage index for the city where the facility is located. This clean claim was billed requesting the surgical procedure be paid at 130% of CMS with separate reimbursement for our implants. According to Texas Workers Compensation Rule 134.402, "Implantable devices are reimbursed at the providers cost plus 10% up to $1,000.00 per item or $2,000.00 per case."

Amount in Dispute: $4524.73

Respondent's Position

"…Per the itemized billing, the Provider only used 5 anchors in this procedure: 2 suture anchor swivelock double loaded; 2 suture anchor 4.75 x 14 mm; and 1 anchor bc swivelock 3.9 x 17.9mm. …It should be noted in the invoices that two types of suture anchors used, the double loaded and

the 4.75 x 14 mm, are sold in boxes, not individually. The Carrier's review indicated these are boxes of five, so the cost has been divided by the number of units in the box. Furthermore, although 5 units are indicted in the itemized billing, the operative report indicates only 2 medical row anchors were used. With the cost of $2,227 plus the mark-up of 10%, total implantable reimbursement is $2,449.70. Reimbursement for the surgical procedure itself is $8,373.04. Combining this with the implantable reimbursement of $2,449.70, total reimbursement is $10,822.74. As the Carrier has already paid $12,881.60, no additional reimbursement is due."

Response submitted by: Travelers

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 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.403 sets out the fee guidelines for outpatient hospital services.

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.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- 4097 – Paid per fee schedule; Charge adjusted because statute dictates allowance is greater than provider's charge.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.

Issues

1. What rule is applicable to reimbursement?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment for implants rendered at an outpatient hospital for date of service April 24, 2023. Both the requestor and respondent reference DWC Rule §134.402 however that rule applies to Ambulatory Surgical Centers.

   The NPI listed on the medical bill is 1871599183. This NPI indicates the requestor, Baylor Scott & White Surgical Hospital – Fort Worth as a General Acute Care Hospital.

   The review for the implants will be reviewed per fee guideline for Outpatient Hospitals.

2. DWC Rule 28 TAC §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.

   Review of the submitted documentation found the following.

   - Suture Anchor Swivelock as identified in the itemized statement. The submitted invoice indicates, DBL Loaded 4.75 mm BC SWVLK, unit of measure "box" with a quantity of "2". This invoice does not indicate the per unit cost. No payment can be made.

   - Suture Anchor 4.75 X 14M as identified in the itemized statement and labeled on the invoice as Corkscrew FT, BC, Suturetape, 4.75, unit of measure "box" for a quantity of "2". This invoice does not indicate the per unit cost. No payment can be made.

   - "Anchor BC Swivelock 3.9" as identified in the itemized statement and labeled on the invoice as "BC SWIVELOCK 3.9X17.9MM" with a cost per unit of $667.00.

   The total billed amount for Revenue Code 278 under HCPCS Code C1713 was $8467.00. The cost supported by invoice was $667.00. Ten percent of this amount is $66.70. The total allowed for implants supported by invoice is $733.70. The insurance carrier paid $8,467.00. 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

		September 29, 2023
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 electronico CompConnection@tdi.texas.gov.