TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Orthopedic & Spine Hospital

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-24-0958-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
January 3, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 1, 2023	C1713	$3,415.50	$0.00
August 1, 2023	C1762	$3,358.37	$0.00
August 1, 2023	C1769	$0.00	$0.00
	Total	$6,773.87	$0.00

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" dated December 21, 2023 that states, "According to TX Workers Compensation fee schedule the expected reimbursement for DOS 08/01/2023 is $18,836.52. Per TX Rule 134.402, implants should be reimbursed at manual cost plus 10%. However, CPT code C1713 and C1769 disallowed payment for being inclusive, and codes are separately payable."

Amount in Dispute: $6,773.87

Respondent's Position

"Texas Mutual insurance reimbursed the health care provider as follows for implants requested... ...For a total of $3,271.93 + 10% ($327.19) = $3,599.12. Our position is that no additional

payment is due."

Response submitted by: Texas 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) §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 disputed service(s) with the following claim adjustment codes.

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- D25 – Approved non network provider for Workwell, TX network claim per Rule 1305.153(c).
- 217 – The value of this procedure is included in the value of another procedure performed in this date.
- 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup.
- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 767 – Paid per O/P FG at 200%: Implants not applicable or separate reimbursement (with cert) not requested per Rule 134.403 (G).

- 897 – Separate reimbursement for implantables made in accordance with DWC Rule Chapter 134; subchapter (E) health facility fees.
- 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 rule is applicable to reimbursement?

Findings

1. The requestor lists the Codes C1713 and C1762 as being in dispute for an amount of $6,773.87 for date of service August 1, 2023 on the DWC 60 at the time of request for MFDR.

   Review of the submitted itemized statement found the following items billed under Code C1713. Review of the submitted Smith and Nephew Sales Order dated August 1, 2023 found the following.

   - Device Fixation Ultrabut, one unit, with an invoice cost of $305.00.
   - Screw Biosure 10m x 25mm, one unit, with an invoice cost of $260.00
   - Anchor Q-Fix 2.8mm 4 units, with a unit cost of $375.00, and total cost of $1500.00.
   - Screw Biosure 7mm x 25mm one unit, with an invoice cost of $260.00
   - Screw 7mm x 20mm Biosure one unit, with an invoice cost of $260.00
   - Screw 9mm x 20mm Biosure one unit, with an invoice cost of $260.00
   - Screw Biosure 9mm x 25mm one unit, with an invoice cost of $260.00

   DWC Rule 28 TAC §134.403 (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 itemized statement submitted with this request found the following items submitted under Code C1762.

   - Allograft Posterior Tibi, one unit billed amount $1625.00.
   - Allograft Semitendinosus, one unit billed amount $1600.00
   - Graft Bone Achilles Tend, one unit billed amount $3100.00

Review of the submitted information found for the items in dispute found the requestor submitted a screen shot titled "BOSHA Material Storage" for the items listed above.

This item is not a manufacturer's invoice that supports the cost of the requested implants.

DWC Rule 28 TAC §134.403(g)(1) states, "A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

The requestor's certification included with this request for MFDR is not supported for the items listed above. No payment is recommended.

- Procedure code 27427 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5114. The OPPS Addendum A rate is $6,614.63 multiplied by 60% for an unadjusted labor amount of $3,968.78, in turn multiplied by facility wage index 0.9562 for an adjusted labor amount of $3,794.95.

  The non-labor portion is 40% of the APC rate, or $2,645.85.

  The sum of the labor and non-labor portions is $6,440.80.

  The Medicare facility specific amount is $6,440.80 multiplied by 130% for a MAR of $8,373.04.

The total net invoice amount (exclusive of rebates and discounts) is $3,187.26. 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 $318.73. The total recommended reimbursement amount for the implantable items is $3,505.99.

The total recommended reimbursement for the disputed services is $11,879.03. The insurance carrier paid $11,972.16. Additional payment is not 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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 2, 2024 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.