



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Surgical Hospital

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-24-2515-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

July 15, 2024

Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| February 7, 2024 | C1713 | \$3,105.18 | \$0.00 |
| Total | | \$3,105.18 | \$0.00 |

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a document titled "Reconsideration" dated July 2, 2024 that states, "According to TX Workers Compensation Fee Schedule the expected reimbursement for DOS 2/7/2024 is \$21,894.23. Per TX Rule 134.402, implants should be reimbursed at manual cost plus 10%. Previous payment received totaled \$18,789.05."

Amount in Dispute: \$3,105.18

Respondent's Position

"...Fort Worth Surgicare Partners contends we did not reimburse correctly for the implants. According to the itemized statement (attached) revenue code 0278 was billed for the following items the breakdown of how the implants were reimbursed... Total implant reimbursement was \$10,256.40. 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 reimbursement guidelines for outpatient hospital services.

Denial Reasons related to implants

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 897 – Separate reimbursement for implantables made in accordance with DWC Rule Chapter 134; Subchapter (E) health facility fees.
- CAC - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC – 193 – Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.
- 350 – In accordance with TDI-DWC 134.804, this bill has been identified as a request for reconsideration or appeal.
- DC4 – No additional reimbursement allowed after reconsideration.

Issues

1. What is the rule applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment of implants rendered during outpatient surgical procedure in February 2024. The insurance carrier made payment based on workers compensation jurisdictional fee schedule and DWC Rules. Review of the submitted medical bill, itemized invoice and manufacturer's invoices finds the following.

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.

The following items were billed under Revenue Code 278 and HCPCS code C1713.

- Anchor Swivelock SP BC 4 (2) units billed amount \$4390.40. Manufacturers invoice supports cost of \$784.00 each. Total cost \$1,558.00 plus 10% (\$156.80) = \$1,724.80.
- Staple Tendon Arthroscope (1) unit billed amount \$367.50. Manufacturers invoice supports cost of \$367.50 plus 10% (\$36.75) = \$404.25.
- Anchors Bone 3 w Arthroscope (1) unit billed amount \$682.50. Manufacturers invoice supports cost of \$682.50 plus 10% (\$68.25) = \$750.75.
- Anchor Sut 4.75mm x 19.1 (1) unit billed amount \$784.00. Manufacturers invoice supports cost of \$784.00 plus 10% (\$78.40) = \$862.40.
- Anchor Sut 4.75mm x 19.1 (1) unit billed amount \$784.00. Manufacturers invoice supports cost of \$784.00 plus 10% (\$78.40) = \$862.40.
- Suture Anchor Swivelock (1) unit billed amount \$2303.50. Manufacturer's invoice supports cost of \$2,303.50 plus 10% (\$230.35) = \$2533.85.

2. The total recommended reimbursement for the implants represented by HCPCS code C1713 is \$7,138.45. The insurance carrier supports a payment of \$7,137.90 made on April 1, 2024. 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

Signature

Medical Fee Dispute Resolution Officer

August 9, 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 electrónico CompConnection@tdi.texas.gov.