



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Orthopedic & Spine Hospital

Respondent Name

Texas Mutual Insurance Co.

MFDR Tracking Number

M4-25-0309-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

October 7, 2024

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
May 16, 2024	C1713	\$483.98	\$0.00

Requestor's Position

"In Accordance to TX Rule 134.402, implants should be reimbursed at manual cost plus 10% (\$2000 max). Please note that CPT code C1713 was not paid correctly per TX work comp guidelines. We ask that you reprocess and remit payment for remaining balance due. C1713- UB TX O/P: Implant@Manual Cost +10%=\$7,699.98."

Amount in Dispute: \$438.98

Respondent's Position

"Texas Mutual has reimbursed the implants used per the op report at invoice cost +10%... For a total implant reimbursement of \$7,216.00. Our position is that no additional payment is due."

Response Submitted by: Texas Mutual Insurance Co.

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.

Adjustment Reasons

The insurance carrier reduced or denied payment for the disputed services with the following claim adjustment codes:

- P12 – WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 897 - SEPARATE REIMBURSEMENT FOR IMPLANTABLES MADE IN ACCORDANCE WITH DWC RULE CHAPTER 134; SUBCHAPTER (E) HEALTH FACILITY FEE.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION.
- W3 & 350 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. What rules apply to the reimbursement of the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute involves outpatient hospital facility services in which separate reimbursement for surgical implantable items was requested on the medical bill.

DWC finds that 28 TAC §134.403 applies to the reimbursement of the services in dispute.

28 TAC §134.403 (e) states in pertinent part, regardless of billed amount, when no specific fee schedule or contract exists, reimbursement shall be the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

DWC Rule 28 TAC §134.403 (f) states in pertinent part "the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment

amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied. (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent...

(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-ons per admission."

- The requestor is seeking additional reimbursement in the amount of \$483.98 for surgical implantable items billed under disputed CPT code C1713. A review of the submitted medical bill finds that the facility provider requested separate reimbursement for the surgical implantable items. A review of the submitted itemized statement finds that the requestor charged for implantable items billed under code C1713 in the total amount of \$7,000.00.

Per review of the submitted operative report, implant log and implant invoice, in accordance with Rule 28 TAC §134.403, DWC finds the following:

Review of the itemized statement indicates a total to 19 items billed under Revenue Code 278 and code C1713.

The submitted "Operative Report" documents the following products were implanted:

"IMPLANTS: Fusion Ortho anatomic distal fibula plate; 3 x 3.5mm cortical screws proximal to the fracture; 4 x 2.7mm locking screws distal to the fracture. 1/3rd tubular plate medially with 3 x 3.5mm cortical screws and 2 x 3.5mm locking screws."

Each plate has a supported cost of \$2,800.00 x 2 = \$5,600.00

Each screw has a supported cost of \$80.00 x 12 = \$960.00

Total supported cost \$6,560.00 x 10% = \$656.00 for total implant MAR of \$7,216.00. No additional payment is recommended.

Name from itemized statement	Item #	cost/unit	# units utilized	total cost	10% not to exceed \$1000	Total allowed per implantable
Plate lateral fibula	AK-LF-1009	\$2,800.00	1	\$2,800.00	\$280.00	\$3,080.00
Screw locking 2.7 x 14M	MF-LK-2714	\$80.00	4	\$320.00	\$32.00	\$352.00
Screw 3.5 x 14	MF-NL-3514	\$80.00	3	\$240.00	\$24.00	\$264.00
Plate 7 Hole utility	AK-UP-0007	\$2,800.00	1	\$2,800.00	\$280.00	\$3,080.00
Screw 3.5 x 32 non-locking	MF-NL-3532	\$80.00	2	\$160.00	\$16.00	\$176.00
Screw non-locking 3.5 x 30MM	MF-NL-3530	\$80.00	1	\$80.00	\$8.00	\$88.00
Screw 3.5MM x 28MM Compr	MF-NL-3528	\$80.00	0	\$80.00	\$8.00	\$00.00

Screw 3.5 x 34	MF-NL-3534	\$80.00	0	\$80.00	\$8.00	\$00.00
Screw locking 3.5 x 8MM	MF-LK-3508	\$80.00	2	\$160.00	\$16.00	\$176.00
Wire olive CD-SB-055	Disposable	\$200.00	xxx	\$00.00	00.00	00.00
		Total:		\$6,560.00	\$656.00	\$7,216.00

Therefore, in accordance with 28 TAC §134.403, DWC finds that the requestor is entitled to reimbursement for surgical implantable items in the total amount of \$7,216.00.

A review of the submitted EOBs finds that the insurance carrier paid \$7,216.00 for the surgical implantable items in dispute.

DWC finds that the requestor is not entitled to additional reimbursement.

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

November 13, 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.