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
Fort Worth Surgicare Partners

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-25-0560-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
November 1, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 1, 2024	C1713	$1,648.90	$0.00
May 1, 2024	C1781	$283.50	$0.00
	Total	$1.932.40	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" dated October 18, 2024 that states, "Per EOB received, implants were not paid correctly per TX work comp guidelines. According to TX Rule 134.402, implants should be reimbursed at manual cost plus 10%, and implant invoices are enclosed for review."

Supplemental response submitted December 23, 2024

"Provider has received an additional $283.50 and still owed a balance of $1,648.90. Please resume with dispute M4-25-0560-01."

Amount in Dispute: $1,932.40

Respondent's Position

"This letter acknowledges receipt of your Liberty Health Care Network (HCN) complaint on 11/13, 2024."

Supplemental response November 27, 2024

"The bill has been reviewed and adjusted for payment – copies of EOBs will be submitted for your review once available."

Response submitted by: Liberty 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

- 16 – Claim/service lacks information which is needed for adjudication.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 4915 – The charge for the services represented by the code is included 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.
- 5372 – Insurance carrier payment to the health care provider shall be according to commission medical policies and fee guidelines in effect on the date(s) of service(s). Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of the liability under Labor Code 408.024.
- 8 – The supply charge was disallowed as it was not adequately identified. Please resubmit with invoice.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 11 – The recommended allowance for the supply was based on the attached invoice.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

- 305 – The charge for this procedure, material, and or service is not normally billed. For Texas Jurisdiction claims only, per Texas Labor Code Section 413.031 and 28 Tex. Admin. Code sections 133.308(H), (I), after reconsideration. You may seek review of a denial of medical necessity through a TDI-DWC-appointed independent review organization.

Issues

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

Findings

1. The requestor is seeking additional payment of codes C1713 and C1781. These codes represent implant charges. The respondent submitted a position statement on November 27, 2024 that states in pertinent parts, "The following payment is being made regarding C1713 X 8 and C1781. Item 4566 bioinductive implant invoice amount $2,835.00 x 10% = $3,118.50. An additional $283.50 is issued. …One unit of C1713 x 1 is denied as this is not an implant as described in the TX fee schedule. …AR-4068C Suture lasso is not an implant so it is not eligible for payment under rev 278."

   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.

   The following items were billed under Revenue Code 278 on the itemized statement.

   - Anchor Fibertak RC soft 1 unit - $2016.00
   - Anchor Fibertak RC soft 1 unit - $784.00
   - Anchor Bone SP Fbrtak RC 1 unit - $784.00
   - Anchors Bone 3 w arthro 1 unit - $725.00
   - Staple Tendon Arthroscop 1 unit - $450.00
   - Lasso Sut Crescent Quick 1 unit $267.00
   - Suture anchor biocompsi 2 units $1390.00
   - Implant mesh bioninducitiv 1 unit - $2835.00
   - Total of implant charges $9,251.00

Review of the submitted "Operative Report" indicates.

IMPLANTS:

1. Arthrex 2.9-mm All-suture anchors x3 loaded with tape for medical row fixation and 4.75-mm SwiveLock anchor x2 for lateral row fixation.

2. Smith & Nephew Regeneten patch with associated soft tissue staples

The narrative of the operative report indicates, "…placed three all suture anchors medially… …I did elect to perform Regenteen patch…"

Based on review of the documentation the following items were supported by the operative report and submitted invoices.

- "Anchor Fibertak RC soft" as identified in the itemized statement and labeled on the invoice as ""SP FBRTAK RC Tgr/Tpe" with a cost per unit of $784.00.
- "Anchor Fibertak RC soft" as identified in the itemized statement and labeled on the invoice as "SP FBRTAK RC Tgr/Tpe" with a cost per unit of $784.00.
- "Anchor bone SP fbrtak RC soft" as identified in the itemized statement and labeled on the invoice as "SP FbrTak RC" with a cost per unit of $784.00.
- "Anchors bone 3 w arthro smith & nephew 2139502" as identified in the itemized statement and labeled on the invoice as "bone anchors 3 w arthro" with a cost per unit of $725.00.
- "Staple tendon arthroscop" as identified in the itemized statement and labeled on the invoice as "Tendon anchors" with a cost per unit of $450.00.
- "Lasso sut crescent quick". Not found in operative report.
- "Suture anchor biocomposi" – 2 units as identified in the itemized statement and labeled on the invoice as "DBL Loaded 4.75mm bio-comp swvlk" with a cost per unit of $695.00 for a total cost of $1390.00.
- "Implant mesh bioinductiv implant mesh" as identified in the itemized statement and labeled on the invoice as "bioinductive implant w/arth" with a cost per unit of $2,835.00.

The total net invoice amount (exclusive of rebates and discounts) is $7,752.00. 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 $775.20. The total recommended reimbursement amount for the implantable items is $8,527.20.

3. The total recommended reimbursement for the disputed services is $8,527.20. The insurance carrier paid $8,527.20. No additional payment is due.

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	February 7, 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. 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.