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
Phoenix Insurance Co.

MFDR Tracking Number
M4-25-0685-01

Carrier's Austin Representative
Box Number 5

DWC Date Received
November 13, 2024

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
July 9, 2024	C1713	$2,449.98	$2,449.98
July 9, 2024	C1889	$7,040.00	$7,040.00
July 9, 2024	**Total MAR** for outpatient surgery services		$18,022.63
September 4, 2024	Previous payment adjustment		-$13,127.16
	Total	$9,489.98	**$4,895.47**

Requestor's Position

"Per EOB received payment was disallowed for Rev code 278 for implants being inclusive. Please note that separate reimbursement was requested in Box 80 of UB-04 form for implants. According to TX Rule 134.402, implants should be reimbursed at manual cost plus 10%, and implant invoices are enclosed for review. Please reprocess and remit payment for remaining balance due.

"C1713-UB TX O/P: Implant@ Manual Cost +10%=$2,449.98

C1889-UB TX O/P: Implant@Manual Cost =10%=$7,040.00

29827-UB TX O/P: Surgical @130% GARR=$8,532.65"

Amount in Dispute: $9,489.98

Respondent's Position

"The Provider originally submitted the billing without requesting separate reimbursement for the implantables. The Carrier reimbursed the Provider at 200% of the Medicare base rate or $13,127.16 as documented on the Explanation of Reimbursement dated 08-16-2024. The Provider then submitted a request for reconsideration requesting separate reimbursement of the implantables. With the implantables separately reimbursed, the 130% conversion factor is utilized instead of the 200% conversion factor, resulting in reimbursement of the procedure at $8,532.65. Additionally, the implantables are then reimbursed separately for three PEEK anchors ($420.75 each) and two Iconix anchors ($482.50 each). This results in total implantable reimbursement with the 10% mark-up of $2,449.98. Please note that although a Striker Inspace implantable is listed on the implant log, there is no invoice submitted by the Provider to support the use or reimbursement of that item. Total reimbursement for the procedure At [sic] $8,532.65 plus separate reimbursement for the implantables at $2,449.98 equals total reimbursement under this methodology of $10,982.63… The carrier contends the Provider is not entitled to additional reimbursement."

Response Submitted by: Travelers

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031and 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:

- 97 – 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 service represented by the code is included/bundled into the total facility payment and does not warrant a separate payment status indicator determines the service is packaged or excluded from payment.
- P12 – WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- W3 – BILL IS A RECONSIDERATION OR APPEAL.

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 947 – UPHELD. NO ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED.
- 5416 – A copy of the invoice for implant is required before payment can be considered.

Issues

1. What rules apply to the reimbursement of the services in dispute?
2. Did Baylor Orthopedic & Spine Hospital request separate implant reimbursement on the medical bill in accordance with 28 TAC §134.403?
3. What is the supported cost of the implants in dispute?
4. Is Baylor Orthopedic & Spine Hospital 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."

2. In response to this medical fee dispute resolution (MFDR) request, the insurance carrier asserts that Baylor Orthopedic & Spine Hospital did not request separate reimbursement for implantable items on the original medical bill. The insurance carrier states that Baylor

Orthopedic & Spine Hospital requested separate implant reimbursement on its request for reconsideration of the medical bill.

A review of the submitted medical bill finds that Baylor Orthopedic & Spine Hospital requested separate implant reimbursement in field 80 of the UB-04 medical bill in accordance with 28 TAC §134.403.

DWC finds that the greater weight of evidence supports that Baylor Orthopedic & Spine Hospital requested separate reimbursement for implants in accordance with 28 TAC §134.403.

3. The requestor is seeking reimbursement for surgical implantable items billed under disputed procedure codes C1713 and C1889 with revenue code 278.

   Per the submitted itemized statement, the requestor charged for implantable items billed under codes C1713 and C1889 in the total amount of $8,627.25.

   A review of the submitted operative report, implant log and implant invoice, finds the following supported costs:

   The itemized statement indicates that the requestor billed for a total of 6 implantable items under Revenue Code 278 with codes C1713 and C1889.

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

   IMPLANTS: 1. Iconix Speed Anchor x 2
   2. Omega 4.75MM Peek knotless Anchor x 3
   3. Stryker InSpace Device medium x 1

   - Iconix Speed Anchor x 2 at $482.50 each, billed under procedure code C1713 and revenue code 278, has a supported cost of $965.00.
   - Omega 4.75MM Peek knotless anchor x 3 at $420.75 each, billed under procedure code C1713 and revenue code 278, has a supported cost of $1,262.25.
   - Stryker InSpace Device medium x 1, billed under procedure code C1889 and revenue code 278, has a supported cost of $6,400.00.
   - DWC finds that there was a total of six implanted surgical products provided on the disputed date of service with a total supported cost of $8,627.25.

4. The requestor is seeking reimbursement in the amount of $9,489.98 for disputed procedure codes C1713 and C1889, representing surgical implantable items provided on July 9, 2024, for which separate reimbursement was requested on the medical bill.

   A review of the submitted documentation finds that on the disputed date of service, the requestor rendered and billed for surgical procedure code 29827-LT in addition to requesting separate reimbursement on the same bill for the implantable surgical items referenced above.

   DWC Rule 28 TAC §134.403 (d), which applies to the services in dispute, requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

DWC Rule 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…"

The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non-labor portion determines the Medicare specific amount.

A review of the submitted medical bill in accordance with the applicable fee guidelines referenced above is shown below.

- Procedure code 29827 has status indicator J1, for outpatient comprehensive packaging.
- This code is assigned APC 5114. The OPPS Addendum A rate is $6,816.33 multiplied by 60% for an unadjusted labor amount of $4,089.80, in turn multiplied by facility wage index 0.9382 for an adjusted labor amount of $3,837.05.
- The non-labor portion is 40% of the APC rate, or $2,726.53.
- The sum of the adjusted labor amount and the non-labor portion is $6,563.58.
- Therefore, the Medicare facility specific amount is $6,563.58.
- The facility provider requested separate reimbursement for implantable items on the medical bill. Therefore, the Medicare facility specific amount is multiplied by 130% for a MAR of $8,532.65 for procedure code 29827-LT rendered on the disputed date of service.

In accordance with 28 TAC §134.403, separate reimbursement for the surgical implantable items is calculated as follows:

Name from itemized statement	Item #	cost/unit	# units utilized	total cost	10% not to exceed $1000	Total allowed per implantable
Anchor Omega 4.75MM Peek	3910-500-471	$420.75	3	$1,262.25	$126.23	$1,388.48
Iconix Speed Anchor w/2	3910-500-920	$482.50	2	$965.00	$96.50	$1,061.50
InSpace US medium 0131	0131	$6,400.00	1	$6,400.00	$640.00	$7,040.00
		Total:	6	$8,627.25	$862.73	**$9,489.98**

DWC finds that the requestor is entitled to separate reimbursement in the amount of $9,489.98 for the disputed surgical implantable items provided on July 9, 2024.

DWC finds that the total MAR for outpatient hospital services rendered on July 9, 2024, is $18,022.63.

A review of the submitted explanation of benefits finds that the insurance carrier previously reimbursed a total amount of $13,127.16 for outpatient hospital facility services rendered on the disputed date of service.

Therefore, DWC finds that additional reimbursement in the amount of $4,895.47is due to the requestor for outpatient hospital services rendered on July 9, 2024.

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 established that additional reimbursement is due in the amount of $4,895.47.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent, Phoenix Insurance Co., must remit to the Requestor, Baylor Orthopedic & Spine Hospital, $4,895.47 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 14, 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.