TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Surgical Hospital

Respondent Name
Standard Fire Insurance Co

MFDR Tracking Number
M4-25-0746-01

Carrier's Austin Representative
Box Number 5

DWC Date Received
December 3, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 31, 2024	C1713	$5852.00	$0.00
July 31, 2024	29827	$-4,594.51	$0.00
	Total	$1,257.49	$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 November 14, 2024 that states, "Per EOB received, Rev code 278/Implants was disallowed payment. Please note that separate reimbursement was requested in Box 80 of the UB-04 form for Implants."

Amount in Dispute: $1,257.49

Respondent's Position

"The Carrier reimbursed the Provider at 200% of the Medicare base rate or $13,127.16… With the implantable separately reimbursed, the 130% conversion factor is utilized instead of the 200% conversion factor, resulting in reimbursement of the procedure at $8,532.65. …This results in total implantable reimbursement with the 10% mark-up of $3,449.60. Total reimbursement for the procedure at $8,532.65 plus separate reimbursement for the implantables at $3,449.60 equals total reimbursement under this methodology of $11,982.25."

Response submitted by: Travelers

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 of outpatient hospital services.

Denial Reasons

- 97/4915 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- W3 – Bill is a reconsideration or appeal.
- P12 – Workers' Compensation jurisdictional fee schedule adjustment.
- 947 – Upheld. No additional allowance has been recommended.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 802 – Chare for this procedure exceeds the OPPS schedule allowance.

Issues

1. What services are in dispute?
2. Is the respondent's position supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking payment of services rendered July 31, 2024 under Code C1713. Review of the submitted medical bill found the charges billed for code C1713 was $5,320.00 with a quantity of seven. The submitted itemized bill indicates the following items.
    - Implant system 4.75 BC SW
    - Anchor Fibertak RC Soft
    - Anchor Bone SP Fbrtak RC
    - Anchor Sut 4.75mm x 19.1

The operative report indicates the following.

Implants:

- Arthrex 2.9 mm all-suture anchor x1
- Arthrex 4.75-mm SwiveLock anchor x3 for rotator cuff repair with associated suture for rotator cuff repair and biceps tenodesis.

Review of the submitted Arthrex Invoice dated July 31, 2024 indicates one AR-1665BCS with a cost of $1,334.00.

DWC 28 TAC Rule §134.403 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."

Insufficient evidence was found in the operative or the submitted invoice dated July 31, 2024 for all other items billed under Revenue Code 278. This item is the ONLY implant considered in this review.

DWC TAC 28 Rule §134.403 (g) states in pertinent part, "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."

Based on above the cost of the implant supported by invoice and operative report is $1,334.00. This amount multiplied by 10% equals $1,467.40.

2. The respondent states in their position statement, "…Total reimbursement for the procedure at $8,532.65 plus separate reimbursement for the implantables at $3,449.60 equals total reimbursement under this methodology of $11,982.25. As the Provider was reimbursed $13,127.16 on the initial submission, there is an overpayment for these services…" The requestor's submitted DWC60 lists Code 29827 with a payment amount of $13,127.16 and negative -4,594.51 as amount in dispute. The fee guideline based on applicable DWC Rule is shown below.

    - Procedure code 29827 has status indicator J1. 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 labor and non-labor portions is $6,563.58.

      The Medicare facility specific amount is $6,563.58 is multiplied by 130% for a MAR of $8,532.65.

The DWC finds the respondent's position regarding the MAR of the procedure is supported. The amount allowed by the insurance carrier for the implants differs as the Division did not find supporting evidence of items submitted on the medical bill being utilized in the operation or the cost was not supported by invoice on or before the date of service.

3. The total recommended reimbursement for the disputed services is $10,000.05. The insurance carrier paid $13,127.16. 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 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	January 31, 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.