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
M4-25-1128-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
January 28, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 11, 2024	C1713	$2,545.84	$0.00
	Total	$2,545.84	$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 January 13, 2025 that states, "Per EOB received CPT code C1713 was not paid correctly per TX work comp guidelines. According to TX Rule 134.402, implants should be reimbursed at manual cost plus 10%."

Supplemental response April 10, 2025

"Partial payment has bee received and a balance of $1,057.66 still owed. Please continue with dispute."

Amount in Dispute: $2,545.84

Respondent's Position

"The Carrier has reviewed the documentation and contends the Provider is entitled to additional reimbursement, but not in the amount sought. ...Additionally, the C1713 implantable are then reimbursed separately for one tendon staple ($450.00), three SwiveLock anchors ($784.00 each),

and three FiberTak anchors ($784.00 each). Please note that the bone anchors, tendon anchors, and implant system are not substantiated in the documentation. This results in total implantable reimbursement with the 10% mark-up of $4,602.51. CPT code C1781 was also reimbursed at $3,118.50. Total reimbursement for the procedure plus separate reimbursement for the implantables C1713 and C1781 provides additional reimbursement under this methodology of $1,466.11. … With the supplemental reimbursement being issued, 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 §413.031 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

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – Bill is a reconsideration or appeal.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 5554 – Paid per invoice cost plus any applicable state markup.
- 947 – Upheld, no additional allowance has been recommended.
- 4097 – Paid per fee schedule; Charge adjusted because statue dictates allowance is greater than provider's charge.
- 2008 – Additional payment made on appeal/reconsideration.
- 8993 – Additional payment made based on State Decision. Payment is final.

Issues

1. What service is in dispute?
2. What is the rule applicable to reimbursement?

Findings

1. The requestor is seeking payment additional reimbursement of implants rendered as part of outpatient hospital surgical procedure for date of service September 11, 2024. The insurance carrier states in their position statement, "The Provider was originally reimbursed without 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 10-18-2024. 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. …Total reimbursement for the procedure plus separate reimbursement for the implantables C1713 and C1781 provides additional reimbursement under this methodology of $1,466.11.. The insurance carrier submitted evidence to support $1,466.11 was paid to the requestor on February 7, 2025 via check number 896D 99318456. The requestor acknowledged receipt of this payment but wished to continue with the dispute."
2. DWC Rule 28 TAC §134.403 (g) states in pertinent parts, 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.

   Review of the information submitted with this request for MFDR included the following.

   - Purchase order from Arthrex was created September 13, 2024 (the date of service in dispute is September 11, 2024).
   - Sales order from Arthrex that indicates, "Pricing Disclaimer: This is not an invoice. All prices are estimates and are subject to change without notice, and do not include applicable sales/use or any other relevant transaction based taxes. The pricing on the manufacture's final Invoice is the pricing for this order."

   The information submitted with this MFDR request did not include the manufacturer's invoice. The maximum allowable reimbursement (MAR) cannot be calculated without the manufacturer's invoice. No additional reimbursement 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

		April 16, 2025
Signature	Medical Fee Dispute Resolution Officer	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.