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
Texas Mutual Insurance Co.

MFDR Tracking Number
M4-25-1131-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
January 28, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
May 30, 2024	C1713	$3,474.90	$0.00
May 30, 2024	C1781	$4,603.50	$0.00
	Total:	$8,078.40	$0.00

Requestor's Position

"The charges 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. Please reprocess and remit payment for remaining balance due.

"C1713-UB TX O/P: Implant @ Manual Cost+10%=$9,254.85

C1781-UB TX O/P: Implant @ Manual Cost+10%=$7,722.00

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

Amount in Dispute: $8,078.40

Respondent's Position

"The health care provider requested separate reimbursement for the implants. Reimbursement was made at 130% plus implants at cost + 10%. Implant reimbursement breakdown was as follows.
"Bone anchor x 1 $725.00 + 10% ($72.50) $797.50
Tendon anchor x 1 $450.00 + 10% ($45.00) = $495.00
Bioinductive implant mesh x 1 = $2,835.00 + 10% ($283.50) = $3,118.50
Total of implants reimbursed lines 10 and 11 = $4,411.00.
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 §413.031and 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:

- 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.
- 45 – CHARGE EXCEEDS FEE SCHEDULE MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
- DC3 – ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION.
- 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 services in dispute?
2. Is the requester 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. The requestor is seeking additional reimbursement in the amount of $8,078.40 for surgical implantable items billed under disputed procedure codes C1713 and C1781. 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 codes C1713 and C1781 in the total amount of $15,433.50.

   Procedure code C1713 is described as "Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)".

   Procedure code C1781 is described as "Mesh (implantable)".

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 of 6 items billed under Revenue Code 278 with procedure code C1713 and a total of one item billed under Revenue Code 278 and with procedure code C1781.

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

IMPLANTS: Arthrex Corkscrew 5.5MM BC FT x 3 units; Arthrex Suture Anchor Swivelock x 1 unit; Rotation Cuff Staple/Tendon Anchor x 1 unit; Smith & Nephew Bone Anchor x 1 unit; Bioinductive Implant Mesh x 1 unit.

Each Arthrex Corkscrew 5.5MM has a supported cost of $592.00 x 3 units = $1,776.00

Each Arthrex Suture Anchor Swivelock has a supported cost of $2,303.50 x 1 unit = $2,303.50

Each Tendon Anchor has a supported cost of $450.00 x 1 unit = $450.00

Each Bone Anchor has a supported cost of $725.00 x 1 unit = $725.00

Each Bioinductive Implant Mesh has a supported cost of $2,835.00 x 1 unit = $2,835.00

Total supported cost is $8,089.50 x 10% = $808.95 for total implant MAR of $8,898.45.

Name from itemized statement	Item #	cost/unit	# units utilized	total cost	10% not to exceed $1000	Total allowed per implantable
Suture anchor swivelock	AR-2324BCT-2	$2,303.50	1	$2,303.50	$230.35	$2,533.85
Corkscrew 5.5MM BC FT	AR-1927 BCT	$592.00	3	$1,776.00	$177.60	$1,953.60
Anchors Bone 3 W Arthro	4403	$725.00	1	$725.00	$72.50	$797.50
Staple tendon Arthroscop	2504-1	$450.00	1	$450.00	$45.00	$495.00
Implant Mesh Bioinductive	4566	$2,835.00	1	$2,835.00	$283.50	$3,118.50
		Total:		$8,089.50	$808.95	$8,898.45

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 $8,898.45.

A review of the submitted EOBs finds that the insurance carrier paid $8,898.45 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	April 4, 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.