



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Orthopedic & Spine Hospital

Respondent Name

Travelers Indemnity Co of Connecticut

MFDR Tracking Number

M4-25-0243-01

Carrier's Austin Representative

Box Number 5

DWC Date Received

September 27, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 12, 2024	C1713	\$521.54	\$0.00
March 12, 2024	C1781	\$275.00	\$0.00
Total		\$796.54	\$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 September 18, 2024 that states, "Per EOB received Rev code 278/Implants were not paid correctly per TX work comp guidelines. According to TX Rule 134.402, implants should be paid at manual cost plus 10%."

Amount in Dispute: \$796.54

Respondent's Position

"The Carrier issued reconsideration payment to the Provider in the amount of \$796.54, the same amount requested on the Table of Disputed Services. Evidence of payment and the Explanation of Benefits are attached. The Provider has been reimbursed for the disputed services, and no additional reimbursement is due."

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.
- 251 – The attachment/other documentation that was received was incomplete or deficient.
- 8768 – Review of the submitted documentation does not substantiate or warrant separate payment. The Implant kit billed contains supplies that are not separately reimbursable. For payment consideration re-submit with itemized invoice for cost of implanted item(s) only.
- W3 – Bill is a reconsideration or appeal.
- 1001 – Based on the correct billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure only.
- 2008 – Additional payment made on appeal/reconsideration.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 29 – The time limit for filing has expired.

Issues

1. Is the respondent's position statement supported?

Findings

1. The requestor is seeking additional payment of \$796.54 for implantables rendered during an outpatient hospital stay on March 12, 2024. The insurance carrier states in their position statement, "The Carrier issued reconsideration payment to the Provider in the amount of \$796.54, the same amount requested on the Table of Disputed Services." This statement was supported by document "Payment" detail that indicates.

- Check number 891A-0094098632
- Amount \$796.50
- Band status: Cashed

Based on our review, the Division finds the respondent's position is supported. The amount requested on the provider's DWC60 was paid. No payment 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 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

October 31, 2024

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 electrónico CompConnection@tdi.texas.gov.