



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Surgical Hospital

Respondent Name

Standard Fire Insurance Co

MFDR Tracking Number

M4-25-0637-01

Carrier's Austin Representative

Box Number 5

DWC Date Received

November 13, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 8, 2024	C1713	\$2,088.32	\$0.00
Total		\$2,088.32	\$0.00

Requestor's Position

A position statement was not submitted by the requestor. A document titled "Reconsideration dated November 5, 2024 states "Per EOB received CPT codes C1713 was partially paid, and not paid per TX work comp guidelines. According to TX Rule 134.402, implants should be reimbursed at manual cost plus 10%."

Amount in Dispute: \$2,088.32

Respondent's Position

"All implantable components identified in the operative report were reimbursed at cost plus 10% mark-up. Based on the foregoing analysis, the Provider has not documented entitlement to additional reimbursement for the surgical implantables. 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 §133.210](#) sets out the medical documentation requirement.

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.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- W3 – Bill is a reconsideration or appeal.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 29 – The time limit for filing has expired.
- 1005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 5554 – Paid per invoice cost plus any applicable state markup.
- 2008 – Additional payment made on appeal/reconsideration.
- 4097 – Paid per fee schedule, charge adjusted because statute dictates allowance is greater than provider's charge.
- 170 – Reimbursement is based on the outpatient/inpatient fee schedule.
- 4271 – Per TX Labor Code Sec. 400.207, providers must submit bills to payors within 95 days of the date of service.

Issues

1. Did the requestor submit documentation to support the disputed services?

Findings

1. The requestor is seeking payment of code C1713 – Anchor, screw. The quantity billed was seven, the total billed amount was \$5,034.44. Review of the itemized billing found the following items billed under this code.

- Lasso Sut crescent quick
- Implant system 4.75 BC SW
- Anchor Fibertak RC soft
- Anchor sut 4.75mm x 19.1
- Staple tendon arthroscope
- Anchors bone 3 2 arthro

DWC Rule 28 TAC §133.210 (c) (2) states, In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation

(2) surgical services rendered on the same date for which the total of the fees established in the current Division fee guideline exceeds \$500: a copy of the operative report;

Review of the submitted nursing notes and operative report indicates a date of August 12, 2016. The disputed date of service is May 8, 2024. As the requestor did not meet the documentation requirements of the outpatient surgical services, 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 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 electrónico CompConnection@tdi.texas.gov.