



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Baylor Surgical Hospital at Trophy Club

**Respondent Name**

Texas Municipal League Intergovernmental

**MFDR Tracking Number**

M4-25-1106-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

January 25, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 20, 2024	C1713	\$1,366.42	\$0.00
<b>Total</b>		\$1,366.42	\$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" that states, "Per EOB, 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%. Previous payment received totaled \$17,563.33."

**Amount in Dispute:** \$1,366.42

### Respondent's Position

"The provider is not entitled to any additional monies because the provider to this day has failed to provide proof of the cost to the provider of the implantables."

**Response Submitted by:** Flahive

### Findings and Decision

## Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §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 fee guidelines for implants rendered during an outpatient hospital service.

## Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 353 – This charge was reviewed according to the submitted invoice and documentation.

## Issues

1. Did the requestor support the cost of the billed implants?

## Findings

1. The requestor is seeking additional payment for implants submitted under code C1713 in the amount of \$1,366.42 for date of service August 20, 2024. The following items are indicated under revenue code 278, code C1713 on the itemized statement.
  - Anchor Sut 4.75mm x 19.1 2 units charge amount \$867.20
  - Anchor Fibertak RC Soft 1 unit \$784.00
  - Anchors Bone 3 2 Arthro 1 unit \$1050.00
  - Anchor Fibertak RS Soft 1 unit \$784.00
  - Staple Tendon Arthroscop 1 unit \$700.00
  - Anchor Bone SP Fbrtak RC 1 unit \$784.00
  - Implant System 4.75 BC SW 1 unit \$1334.00

DWC Rule 134.403 (g) 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.”

The invoice submitted by the requestor (Smith & Nephew) indicates.

- Bone Anchors 2 w arthro \$1050.00

The remaining invoice (Arthrex) has an order date of August 22, 2024 and a shipment date of August 22, 2024. This date is after the date of service and will not be considered to support the cost of implants rendered on August 20, 2024.

Based on the submitted Smith & Nephew invoice, the total cost of the bone anchor is \$1050.00. This amount multiplied by 10% = total allowable \$1155.00. The insurance carrier paid \$5,567.10 for charges submitted under code C1713. No additional 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 reimbursement for the disputed services

### **Authorized Signature**

\_\_\_\_\_  
Signature

Medical Fee Dispute Resolution Officer

February 27, 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](http://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 three or email [CompConnection@tdi.texas.gov](mailto: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 tres o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).