



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

North Central Surgical Hospital

**Respondent Name**

Texas Municipal League Intergovernmental

**MFDR Tracking Number**

M4-25-1134-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

January 28, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 14, 2024	111-278	\$2,671.60	\$0.00
<b>Total</b>			

### Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" dated December 11, 2024, that states, "In accordance to the worker compensation guidelines the expected reimbursement for Inpatient services is \$57,118.37. Also, per TX Rule 134.402 implants should be reimbursed at manual cost plus 10%."

**Supplemental response submitted March 27, 2025**

"Payment of \$512.87 was received on 2/24/2025, and balance still owed. Please continue with dispute."

**Amount in Dispute:** \$2,671.60

## Respondents' Position

"The provider failed to submit the implant invoice for the Infuse Kit Bone Graft which was billed under code C1762 in the amount of \$2,170. No additional amount is owed for that code because of the failure to submit the invoice to support the reimbursement. However, during the carrier's re-review of the provider's medical bill, carrier noticed a calculation error the total of \$20,077 plus an add-on of \$2,000 (as 10% would be \$2,007.70, which exceeds implant threshold, therefore only an additional amount of \$2,000 is allowed). The original implant allowable was \$21,575.40. The additional amount owed for implants is \$22,077 -\$21,575.40 (which was previously paid) equals \$501.40 plus interest of \$11.27 totals an additional payment of \$512.87. That additional amount is being paid. However, the provider is not entitled to any monies above that. More specifically, for code C1762, the provider failed to submit the implant invoice, and this is not entitled to any reimbursement for it."

**Response Submitted by:** Flahive, Ogden & Latson

## 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 \(TAC\) §134.404](#) sets out the acute care hospital fee guideline for inpatient services.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.

### Denial Reasons

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

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 353 – This charge was reviewed according to the submitted invoice and documentation.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- U03 – The billed service was reviewed per UR an authorized.

### Issues

1. What rule is applicable to reimbursement?

Findings

1. This dispute regards inpatient hospital facility services for dates of service August 14, 2024, through August 16, 2024. The specifics of the dispute relate to the implant reimbursement. The submitted documentation from the parties indicates that payment was issued in the amount of \$21,575.40 on October 3, 2024, via check number 6214403. The requestor acknowledged an additional payment of \$512.87 was received on February 24, 2025, after the submission of the medical fee dispute request. The total amount paid for the implants was \$22,088.27. The requestor wished to continue with the dispute and seeks additional payment for the implants.

Per §134.404(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-on's per admission.

Review of the submitted documentation found the following.

- Purchase orders from Medtronic USA, Inc
- Loaner Usage Confirmation (LUC)Form from Medtronic

These documents are not invoices from the manufacturer. The maximum allowable reimbursement (MAR) cannot be calculated by applicable DWC fee guideline shown above.

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**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

April 16, 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 3 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 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).