TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Surgical Hospital

Respondent Name
QBE Insurance Corporation

MFDR Tracking Number
M4-25-1282-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 10, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 26, 2024	C1713	$498.78	$498.78
June 26, 2024	C1781	$283.50	$283.50
	Total	$782.28	$782.28

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%."

Amount in Dispute: $782.28

Respondent's Position

The Austin carrier representative for QBE Insurance Corporation is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on February 19, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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

- P13 – Payment reduced or denied based on workers' compensation regulations or payment policies
- P12 Workers' compensation jurisdictional fee schedule adjustment.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Bill is a reconsideration or appeal.

ForeSight Medical reduction

- 6 – Payment was based on published state regulations and in accordance with document provided by your facility.

Issues

1. What is the rule applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of implants rendered during an outpatient hospital surgical procedure on June 26, 2024. The ForeSight Medical explanation of review indicates, "Payment was based on published state regulations and in accordance with documentation provided by your facility."

DWC Rule 28 TAC §134.403 (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. The items billed under code C1713 and C1718 are as follows.

- "Suture Anchor Swivelock" as identified in the itemized statement and labeled on the invoice as DBL Loaded 4.75 mm BC Swvlk with a cost per unit of $460.70
- "Anchor Fibertak RC Soft" as identified in the itemized statement and labeled on the invoice as "FbrTak RC FbrTpe" two units with a cost per unit of $784.00 for a total cost of $1,568.00
- "Anchor Bone 2 w arthro" as identified in the itemized statement and labeled on the invoice as "Bone Anchors 3 w arthro " with a cost per unit of $725.00;
- "Staple Tendon Arthroscope" as identified in the itemized statement and labeled on the invoice as "Tendon Anchors " with a cost per unit of $450.00 at 2 units, for a total cost of $900.00;
- "Implant System 4.75 BC" as identified in the itemized statement and labeled on the invoice as "LNT Implant System 4.75 BC SwiveLock" with a cost per unit of $1,334.00;
- "Implant Mesh Bioinductive" as identified in the itemized statement and labeled on the invoice as "Bioinductive Implant w/arth" with a cost per unit of $2,835.00.

The total net invoice amount (exclusive of rebates and discounts) is $7,822.71. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $782.27. The total recommended reimbursement amount for the implantable items is $8,604.98.

2. The total recommended reimbursement for the disputed services is $8,604.98. The insurance carrier paid $7,822.70. The amount due is $782.28. This amount 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 established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that QBE Insurance Corporation must remit to Baylor Surgical Hospital $782.28 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 7, 2025
Signature	Medical Fee Dispute Resolution Officer	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.