



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Scott & White
Medical

Respondent Name

Nutmeg Insurance Co

MFDR Tracking Number

M4-25-1822-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

April 7, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 5, 2024	Q4331	\$5,632.00	\$0.00
September 5, 2024	A4100	\$477.12	\$0.00
Total		\$6,109.12	\$0.00

Requestor's Position

The requestor submitted a document titled "Reconsideration" dated March 18, 2025 that states, "Per EOB received CPT code Q4331 was disallowed payment, and A4100 was not paid correctly per TX work comp guidelines."

Amount in Dispute: \$6,109.12

Respondent's Position

"The provider was reimbursed in the amount of \$1,161.00 at cost plus 10% for the implants, based on the documents submitted using provider pricing. We locate and allowed 3 Headless Screws, we did not allow supplies, the KWire and Drill Bits. No manufacturer's invoice was provided for accurate pricing and additional review."

Response Submitted by: The Hartford/Foresight

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:

- 7 – The cost of the supply is included in the value of another procedure performed on the same date of service.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- W3 – Bill is a reconsideration or appeal.
- 131 – Claim specific negotiated discount.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 197 - Recommended allowance based on negotiated discount/rate.
- 602 - Charge for this procedure exceeds the OPPS schedule allowance.
- P12 - Workers' compensation jurisdictional fee schedule/adjustment.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on the re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 18 – Exact duplicate claim/service.

Issues

1. Did the requestor support the cost of the disputed implant charges with manufacturer's invoice(s)?

Findings

1. The requestor is requested MFDR for implants rendered during an outpatient hospital procedure on September 5, 2024. The insurance carrier denied the charge as being packaged.

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 calculation of the appropriate reimbursement requires the requestor to submit a manufacturer's invoice to support the cost of the billed implants. The information contained within this request for MFDR did not include a manufacturer's invoice for "Graft Axolotl Ultra 4cm" submitted under code Q4331 or "Matrix Acera Surgical Re" submitted under code A4100.

No payment is recommended as the reimbursement cannot be calculated.

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

May 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. 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.

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.