



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Baylor Orthopedic & Spine Hospital

**Respondent Name**

LM Insurance Corp

**MFDR Tracking Number**

M4-25-2003-01

**Carrier's Austin Representative**

Box Number 60

**DWC Date Received**

April 28, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 13, 2024	C1713	\$4,434.40	\$694.40

### Requestor's Position

The requestor submitted a document titled "Reconsideration" dated March 6, 2025 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%."

**Amount in Dispute:** \$4,434.40

### Respondent's Position

"We have rereview bill for DOS 9/13/2024 and found that C1713 was handled correctly. Six units of the items billed under rev 278, Olive wire and Olive wire non threaded, are denied as these are not considered implants. This is supported in the provider's attachment, page 74 of the dispute filed, where the intraoperative sheets confirm there were only 18 implants as opposed to the 24 units that were billed. On page 23 of the dispute filed, the olive wires are listed under the disposable column CD-MF-0050 and CD-MF-0055, meaning they are not implants per the provider."

**Response submitted by:** Liberty Mutual

## **Supplemental response submitted May 14, 2025 by ForeSight Medical**

"ForeSight's review was in accordance with the Texas Statutes, the Operative Report and Implant Log provided which allows 18 of 24 items..."

### **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 implants rendered as part of an outpatient hospital procedure.

#### Denial Reasons

- 11 – The diagnosis is inconsistent with the procedure.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- ZD74 – Charges for surgical implants are reviewed separately by ForeSight medical. Please contact ForeSight medical directly for all surgical implant inquiries at 813-930-5346.
- 11 – The recommended allowance for the supply was based on the attached invoice.
- 16 – Claim/service lacks information which is needed for adjudication.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

#### 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 as part of an outpatient surgery on September 13, 2024. The insurance carrier made a payment of \$6,944.00 and

maintained this amount at reconsideration and in their response to MFDR. The reasoning behind the payment is stated from ForeSight Medical as, "...the Operative Report and Implant Log provided which allows 18 of 24 items as follows... ..The provider is misrepresenting the amount charged and is misapplying the Texas Statute. Provider incorrectly asserts they are due an amount equal to their "charges + 10%" and not the statutory amount of their "cost + 10%." As such, ForeSight contends the provider was adequately compensated for the implants up to a total allowance of \$6944.00 as calculated... ".

DWC Rule 28 TAC §134.403 (e)(2) states, "Regardless of billed amount, reimbursement shall be: if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

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.

Review of the submitted medical bill and the applicable fee guideline referenced above is shown below.

- "Plate lateral Fibula Rig" as identified in the itemized statement and labeled on the invoice as "AK-LF-1511 Lateral Fib Locking Plate" with a cost per unit of \$2,800.00
- "Screw non-locking 3.5 x" as identified in the itemized statement and labeled on the invoice as "M4-NL-3512 3.5 non-locking screw" with a cost per unit of \$80.00
- "Olive Wire CD-MF-0050" as identified in the itemized statement. Listed on Implant log as disposable. No payment recommended.
- "Olive Wire non-threaded" as identified in the itemized statement. Listed on Implant log as disposable. No payment recommended.
- "Plate posterior Mal 9 hole" as identified in the itemized statement and labeled on the invoice as "AK-MM-1009 Posterior Mal Plate 9 hole" with a cost per unit of \$2,800.00
- "Plate Lateral Fib Locking" as identified in the itemized statement and labeled on the invoice is not supported by the operative report. No payment is recommended.
- "Screw Non-locking 3.5 x 26" as identified in the itemized statement and labeled on the invoice as "MF-NL-3530 3.5 X 30mm non locking" with a cost per unit of \$80.00
- Screw non-locking 3.5 x " as identified in the itemized statement and labeled on the invoice as "MF-NL-3530 3.5 x 30mm non locking with a cost per unit of \$80.00
- "Screw non-locking 2.7x20m" as identified in the itemized statement and labeled on the invoice as "MF-NL-2720 20mm non locking" with a cost per unit of \$80.00
- "Screw non locking 4.0 x" as identified in the itemized statement and labeled on the

invoice as "MF-NL-4045 4.0 x 45mm non locking" with a cost per unit of \$80.00

- "Screw 3.5mm x 28mm Compr" as identified in the itemized statement and labeled on the invoice as "MF-NL-3528 3.5 X 28mm non locking" with a cost per unit of \$80.00
- "Screw locking 2.7 x 14m" as identified in the itemized statement and labeled on the invoice as "MF-LK-2714 2.7 x 14mm locking" with a cost per unit of \$80.00
- "Screw 3.5 x 14 non-locking" as identified in the itemized statement and labeled on the invoice as "M4-NL-3514 3.5 X 14mm non locking" with a cost per unit of \$80.00
- "Screw headed cannulated" as identified in the itemized statement and labeled on the invoice as "FX-HC-4040 4.0 x 40mm headed cannulated" with a cost per unit of \$224.00

The total net invoice amount or cost (exclusive of rebates and discounts) is \$6,944.00. 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 \$694.40. The total recommended reimbursement amount for the implantable items is \$7,638.40.

2. The total recommended reimbursement for the disputed services is \$7,638.40. The insurance carrier paid \$6,944.00. The amount due is \$694.40. 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 LM Insurance Corp must remit to Baylor Orthopedic & Spine Hospital \$694.40 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### **Authorized Signature**

\_\_\_\_\_  
Signature

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

\_\_\_\_\_  
May 28, 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).