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

Requester Name
Baylor Orthopedic and Spine Hospital

Respondent Name
Sentry Casualty Co

MFDR Tracking Number
M4-25-2302-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 19, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 28, 2024	C1713	$1,435.14	$0.00

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" dated April 25, 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: $1,435.14

Respondent's Position

"I have attached the additional payment information as previously stated. This paid addition $379.83 on check # 54104060 issued 6/19/2025."

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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.403 sets out the billing guidelines for implants rendered during outpatient hospital surgery.

Denial Reasons

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

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Did the insurance carrier submit the medical bill per applicable DWC claim filing instructions?

Findings

1. The requester seeks additional reimbursement of implants rendered during an outpatient surgery on October 28, 2024. The insurance carrier reduced the payment based on fee schedule being exceeded or contract. Insufficient evidence was found to support a contract between the two parties.

   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." Review of the submitted documents found.

   - Purchase order created October 29, 2024
   - Arthrex Sales order created October 29, 2024 with indication "This is not an invoice."

   Insufficient evidence was found to support the required manufacturer's invoice needed to calculate the reimbursement allowed by rule.

Conclusion

Based on the evidence presented by both the requester and respondent at the time of adjudication, and upon review of applicable Texas Workers' Compensation rules and Medicare policies, the Division of Workers' Compensation finds:

- The requester did not support the cost of the implants billed with required manufacturer's invoice.
- Therefore, no additional payment can be recommended.

Although not all submitted evidence is discussed in detail, it was fully considered in reaching this determination.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 31, 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 electronico CompConnection@tdi.texas.gov.