



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Surgical Hospital

Respondent Name

Zurich American Insurance Co

MFDR Tracking Number

M4-25-2374-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

May 28, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 6, 2025	C1763	\$428.00	\$0.00
Total		\$428.00	\$0.00

Requestor's Position

The requestor submitted the following from a document titled "Reconsideration" dated May 20, 2025. "Per EOB, CPT code 1763 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: \$428.00

Respondent's Position

"The provider has acknowledged on its DWC 60 that the Carrier already paid it the amount of \$4280. The provider is seeking an additional payment of \$428. The remains the Carrier's position that the provider is not entitled to any additional payment."

Supplemental response submitted June 16, 2025

"Carrier has previously responded to this dispute on 06/12/2025. The carrier reprocessed the provider's bill, recommending payment of an additional \$428 plus interest. Once the provider has received payment, it should withdraw its DWC 60 on the basis the dispute resolved."

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:

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- 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 requestor support implant cost?

Findings

1. The requestor is seeking additional payment for implants rendered during an outpatient hospital procedure on February 6, 2025. The respondent submitted evidence of a payment made in the disputed amount of \$428.00.

The fee calculation of implants is addressed in DWC Rule §134.403 (g) which 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 documentation found no manufacturer's invoice but rather a Product

Usage/Product Order Form. This document does not allow the reimbursement amount to be calculated per the rule shown above. No additional payment 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 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

_____	Medical Fee Dispute Resolution Officer	June 23, 2025
Signature		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.