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
Arlington Orthopedic and Spine Hospital

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-25-2742-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 1, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 24, 2025	C1713	$5,795.50	$0.00
February 24, 2025	C1889	$1,190.00	$0.00
	Total	$6,985.50	$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 June 24, 2025 that states, "Per EOB received, payment was disallowed for CPT codes C1713 and C1889. Please note separate reimbursement was requested in Box 80 of UB-04 form for implants."

Amount in Dispute: $6,985.50

Respondent's Position

"Our initial response to the above reference medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

Response submitted by: Gallagher Bassett

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

- 28 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.
- 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
- 28 TAC §134.403 sets out the rules and fee guidelines for outpatient hospital services.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 16/90084 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 193/90563 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 5682 – Payment for this charge is not recommended without documentation of cost.

Issues

1. Did the requester submit documentation to support the cost of the implants?

Findings

1. The requester is seeking payment of outpatient hospital charges rendered on February 24, 2025. Specifically, codes C1713 and C1889 which represent implants. The insurance carrier denied the charges stating documentation of cost is required.

   DWC Rule 28 TAC §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 documentation found.

   - Material Mgmt Item Inquire
   - Purchase order dated February 26, 2025
   - Sales order created February 21, 2025

As none of the items listed above are the manufacturer's invoice, the insurance carrier's denial for missing information is supported. No 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 Arlington Orthopedic and Spine Hospital has not established that reimbursement of $6,985.50 is due.

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	August 27, 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 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.