



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Baylor Surgical Hospital at
Trophy Club

Respondent Name

Travelers Casualty & Surety Co

MFDR Tracking Number

M4-25-2989-01

Carrier's Austin Representative

Box Number 05

DWC Date Received

July 21, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 3, 2025	111-278	\$2,000.04	\$2,000.00

Requester's Position

"Per EOB received, Rev code 278 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: \$2,000.04

Respondent's Position

"THIS REQUEST FOR MEDICAL FEE DISPUTE RESOLUTION SHOULD BE DISMISSED IN ACCORDANCE WITH RULE 133.307(f)(3)(A) AS THE DISPUTED SERVICES HAVE NOT BEEN BILLED TO THE CARRIER PRIOR TO FILING THE DWC-60."

Response Submitted by: Travelers

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 \(TAC\) §134.404](#) sets out the acute care hospital fee guideline for inpatient services.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – Bill is a reconsideration or appeal.
- 4896 – Payment made per Medicare's IPPS methodology, with the applicable state markup.
- 947 – Upheld, not additional allowance has been recommended.
- 2006 – No additional reimbursement allowed after review of appeal/reconsideration.
- 13 – An additional allowance has been recommended for implants/prosthetics/DME/Supplies.

Issues

1. What rule is applicable to reimbursement?
2. Is requester entitled to additional reimbursement?

Findings

1. This dispute regards inpatient hospital facility services with payment subject to DWC Rule 28 TAC §134.404(e), states, "Except as provided in subsection (h) of this section, **regardless of billed amount**, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) 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.

Per §134.404(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 documentation finds that the separate implantables include:

- "SCREW" as identified in the itemized statement and labeled on the invoice as "Set screw 9.5mm" with a cost per unit of \$126.00 at 5 units, for a total cost of \$630.00;
- "SCREW 7.0 MM" as identified in the itemized statement and labeled on the invoice as "Ti Polyaxial Screw" with a cost per unit of \$791.00 at 2 units, for a total cost of \$1,582.00;
- "ROD" as identified in the itemized statement and labeled on the invoice as "Ti Lordosed Rod" with a cost per unit of \$212.00 at 2 units, for a total cost of \$424.00;
- "SCREW TI POLY" as identified in the itemized statement and labeled on the invoice as "Ti Polyaxial Screw" with a cost per unit of \$791.00 at 2 units, for a total cost of \$1,582.00;
- "SCREW ALIGN ALIF" as identified in the itemized statement and labeled on the invoice as "ALIF Screw 5.00" with a cost per unit of \$1,562.00 at 2 units, for a total cost of \$3,124.00;
- "PLATE A LINK COVER" as identified in the itemized statement and labeled on the invoice as "Align Break off Coverplate" with a cost per unit of \$340.00;
- "ALIGN TI ALIF INTERBODY" as identified in the itemized statement and labeled on the invoice as "Alif Interbody" with a cost per unit of \$8,050.00;
- "ALLOGRAFT ACUPAC" as identified in the itemized statement and labeled on the invoice as "AcuPac x 10cc" with a cost per unit of \$3,100.00 at 2 units, for a total cost of \$6,200.00.

The total net invoice amount (exclusive of rebates and discounts) is \$21,932.00. 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 \$2,000.00. The total recommended reimbursement amount for the implantable items is \$23,932.00.

2. The total allowable reimbursement for the services in dispute is \$23,932.00. This amount is less than the amount previously paid by the insurance carrier \$21,932.00 leaves an amount due to the requestor of \$2,000.00. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester 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 of \$2,000.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled

to additional reimbursement for the disputed services. It is ordered that Travelers Casualty and Surety Co must remit to Baylor Surgical Hospital at Trophy Club \$2,000.00 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

August 15, 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 electrónico CompConnection@tdi.texas.gov.