



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Baylor Surgical Hospital at Trophy Club

Respondent Name

LM Insurance Corp

MFDR Tracking Number

M4-25-3389-01

Carrier's Austin Representative

Box Number 60

DWC Date Received

August 25, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 27, 2025	111-278	\$2,252.09	\$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 August 12, 2025 that states, "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: \$2,252.09

Respondent's Position

"As noted on the implant log sheet the Requestor billed six units of screw sets. It appears that four units of screws set were placed, and two units are noted as "in and out." ...The Carries does agree that additional payment is due for the implants as the TX implant markup was not applied with prior reviews. ...The additional due is \$2,000.00, markup maximum."

Response Submitted by: LM Insurance

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:

- 16 – Claim/services lacks information which is needed for adjudication.
- 4895 – Payment made per Medicare's IPPS methodology, with the applicable state markup.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 11 – The recommended allowance for the supply was based on the attached invoice.
- 309 – The charge for this procedure exceeds the CMS fee schedule allowance.
- 4007 – Paid per fee schedule. Charge adjusted because statute dictates allowance is greater than provider's charge.

Issues

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

Findings

1. This dispute regards the reimbursement of implants rendered during inpatient hospital stay in January of 2025. These services are subject to DWC Rule 28 TAC §134.404. 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 Align Alif 5.0mm" as identified in the itemized statement with a cost per unit of

\$1,562.00 at 2 units, for a total cost of \$3,124.00;

- "Plate A Link, Cover 11-14" as identified in the itemized statement with a cost per unit of \$340.00;
- "Screw Set T-30 63-0000ST" as identified in the itemized statement with a cost per unit of \$126.00; The total number of units supported by implant log sheet was 4 for a total cost of \$504.00
- "Screw Ti Poly 7.0mm x 45" as identified in the itemized statement with a cost per unit of \$791.00 at 4 units, for a total cost of \$3,164.00;
- "Rod 5.5mm x 45mm 63-0055" as identified in the itemized statement with a cost per unit of \$212.00 at 2 units, for a total cost of \$424.00;
- "Intrbody Align TI Alif" as identified in the itemized statement with a cost per unit of \$8,050.00;
- "Allogrft Acupac X10cc " as identified in the itemized statement with a cost per unit of \$3,100.00 at 3 units, for a total cost of \$9,300.00.

The total net invoice amount (exclusive of rebates and discounts) is \$24,906.00.

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 \$26,906.00.

2. The total allowable reimbursement for the services in dispute is \$26,906.00. The amount previously paid by the insurance carrier is \$26,906.00 (\$2,000.00 on September 2, 2025 and \$24,906.00 on June 20, 2025). No additional reimbursement can be 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 Baylor Surgical Hospital at Trophy Club has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the Baylor Surgical Hospital at Trophy Club is entitled to \$0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

September 11, 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.