



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Arlington Orthopedic & Spine

Respondent Name

Tarrant County

MFDR Tracking Number

M4-26-0014-01

Carrier's Austin Representative

Box Number 43

DWC Date Received

September 3, 2025

Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| March 6, 2025 | C1762 | \$1,379.40 | \$0.00 |

Requester's Position

"Per EOB received, bill was partially paid. According to TX Rule 134.402, implants should be reimbursed at manual cost plus 10%."

Amount in Dispute: \$1,379.40

Respondent's Position

The Austin carrier representative for Tarrant County is Sedgwick York Risk Services Grp. The representative was notified of this medical fee dispute on September 3, 2025

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.403](#) sets out the reimbursement guidelines for implants utilized during outpatient surgical services.

Denial Reasons

- 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.
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- 802 – Charge for this procedure exceeds the OPSS schedule allowance
- 877 – Reimbursement is based on the contracted amount.
- 954 – The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance.
- W3 – Bill is a reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Foresight Explanation of Review

- Device payment was based on documentation provided by your facility.

Issues

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

Findings

- 1. The requester is seeking additional reimbursement for implants submitted on the medical bill under code C1762 for date of service March 6, 2025.

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.

No invoice was found for Graft Bone 110 mg Min NT. The reimbursement rate per the applicable fee guideline cannot be calculated.

- 2. The disputed services were billed as implants with separate reimbursement requested. However, the required manufacturers invoice required to support the cost was not found. No additional reimbursement 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 not established that additional reimbursement is due.

Order

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

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

December 10, 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.