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
Baylor Surgical Hospital at Trophy Club

Respondent Name
Employers Preferred Insurance

MFDR Tracking Number
M4-26-0331-01

Carrier's Austin Representative
Box Number 04

DWC Date Received
October 2, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 29, 2025	C1713	$2750.00	$0.00
April 29, 2025	C1776	$4,463.52	$0.00
	Total	$7,213.52	$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 September 19, 2025 that states, "Per EOB, CPT codes C1713 and C1776 were 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: $7,213.52

Respondent's Position

"Employers stands by its denial of payment for the date of service referenced above. The invoice was not submitted by the provider and Employers is unable to price without the manufacturer invoice."

Response submitted by: Ricky D. Green, PLLC

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

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 886 – The procedure was inappropriately billed, The provider has previously billed for an initial/evaluation visit.
- 954 – The allowance for normally packaged revenue and/or service codes have been paid in accordance with the dispersed outpatient allowance.
- B16 – Payment adjusted because 'New patient' qualifications were not met.
- 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.
- 18 – Exact duplicate claim/service
- 247 – A payment or denial has already been recommended for this service.

Issues

1. Is the insurance carrier's denial supported?

Findings

1. The requester is seeking payment for implants rendered as part of outpatient surgery on date of service April 29, 2025. The insurance carrier denied the claim as packaged.

   Review of the submitted medical bill found a request for implants was made. 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. The submitted documentation did not include any manufacturers invoices related to the items billed under Revenue code 278.

   DWC finds reimbursement calculation of the implants cannot be done per the applicable fee guideline as no invoices were submitted to support the cost. No additional payment 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

		October 17, 2025
Signature	Medical Fee Dispute Resolution Officer	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.