



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Baylor Surgical Hospital at Trophy Club

**Respondent Name**

AIU Insurance Co

**MFDR Tracking Number**

M4-26-2699-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

November 12, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 23, 2025	C1713	\$1,289.84	\$0.00
April 23, 2025	C1762	\$144.00	\$0.00
April 23, 2025	C1776	\$508.40	\$0.00
	Total	\$1,942.24	\$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 October 24, 2025 that states, "Per EOB received bill charges 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:** \$1,942.24

### Respondent's Position

"ForeSight's review was in accordance with the Texas Statues, the Operative Report and Implant Log provided which allows 3 of 4 items..."

**Response submitted by:** ForeSight

## 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

#### Foresight

- 10 – Upon review of submitted request for reconsideration, ForeSight has determined that no additional allowance will be made.
- 14 – This item was determined to not have been permanently implanted during the procedure.

#### Sedgwick

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P13 – Payment reduced or denied based on Workers' Compensation jurisdictional regulations or payment policies.
- W3 – Bill is a reconsideration or appeal.
- 1002 – Due to an error in processing the original bill, we are recommending further payment be made for the above noted procedure.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 2008 – Additional payment made on appeal/reconsideration.
- 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.
- 5191 – This amount has been determined to have been paid in excess of the correct allowance; therefore, an overpayment request is being issued.
- 6981 – Charges for surgical implants are reviewed separately by ForeSight Medical.
- 802 – Charge for this procedure exceeds the OPSS schedule allowance.
- 193 – Original payment decision is being maintained. Upon review, it was determined that

this claim was processed properly.

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- N702 – Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
- N600 – Adjusted based on the applicable fee schedule for the region in which the service was rendered.

### Issues

1. What rule is applicable to reimbursement?

### Findings

1. The requester is seeking additional payment of implants rendered during an outpatient hospital surgery on April 23, 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.

Review of the submitted documentation found the following.

- Arthrex invoice for FBRTJ SPDBRG IMP SYS W/ BC WSVLK with an invoice date of April 24, 2025 and a shipped date of April 24, 2025. The date of service in dispute is April 23, 2025. The invoice is after the DOS and will not be considered in the review to determine cost.
- Arthrex invoice for FiberStitch Implant, Curved RC, Rotator Cuff Augmentation Implant System, FiberTak RC Disposables Kit with an invoice date and shipped date of April 28, 2025. This invoice is for items shipped after the April 23, 2025 date of service and will not be considered to determine cost.
- LifeNet Health invoice dated April 28, 2025 for ArthroFLEX Decellularized Dermix. This invoice is after the date of service April 23, 2025 and will not be considered to determine cost.

Based on this review, the Division finds the information submitted by the requester does not support the amount requested for reimbursement of the implants billed under codes C1713, C1762 and C1776. No 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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

December 29, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).