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

Requestor Name
Baylor Orthopedic & Spine Hospital

Respondent Name
Starbucks Corp

MFDR Tracking Number
M4-25-2117-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
May 5, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 17, 2024	24685	$1,163.61	$1,163.61
	Total	$1,163.61	$1,163.61

Requestor's Position

The requestor did not submit a position statement with this request for MFDR.

Amount in Dispute: $1,163.61

Respondent's Position

"Based on the DWC-60, the Requestor is seeking additional payment in the amount of $1,163.61 for services rendered on September 17, 2024 for CPT Code 24685. Respondent submits that **no further reimbursement is owed for CPT Code 24685. Carrier submits that no additional reimbursement is due because Requestor's documentation does not support additional reimbursement**.

Response submitted by: White Espey 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 rules and fee guidelines for outpatient hospital services.

Denial Reasons

- 192 – Non standard adjustment code from paper remittance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- B12 – Re-evaluated; additional payment is recommended.

Issues

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

Findings

1. The requestor is seeking additional payment for outpatient hospital services rendered in September of 2024. The insurance carrier supports payment in the amounts of $11,651.65 on November 8, 2024 via check 145262870 and $311.90 on February 10, 2025 via check 146407362 for a total payment of $11,963.55. The respondent did not allow additional payment based on workers' compensation jurisdictional fee schedule. The applicable DWC fee guideline calculation is shown below.

   DWC Rule 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

DWC Rule 28 TAC §134.403 (e)(2) states in pertinent part, regardless of billed amount, if no contracted fee schedule exits 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.

DWC Rule 28 TAC §134.403 (f) states in pertinent part the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*.

The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent. Review of the submitted medical bill found a request for implants is not applicable.

The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non-labor portion determines the Medicare specific amount. Review of the submitted medical bill and the applicable fee guidelines referenced above are shown below.

- Procedure code 24685 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5114. The OPPS Addendum A rate is $6,816.33 is multiplied by 60% for an unadjusted labor amount of $4,089.80, in turn multiplied by facility wage index 0.9382 for an adjusted labor amount of $3,837.05.

  The non-labor portion is 40% of the APC rate, or $2,726.53.

  The sum of the labor and non-labor portions is $6,563.58.

  The Medicare facility specific amount is $6,563.58 multiplied by 200% for a MAR of $13,127.16.

2. The total recommended reimbursement for the disputed services is $13,127.16. The insurance carrier paid $11,963.55. The amount due is $1,163.61. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor 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 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Starbucks Corp must remit to Baylor Orthopedic & Spine Hospital $1,163.61 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	June 23, 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 electronico CompConnection@tdi.texas.gov.