



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Baylor Surgical Hospital of Fort Worth

Respondent Name

Texas Mutual Insurance Co.

MFDR Tracking Number

M4-25-2429-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

June 3, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
November 20, 2024	29888	\$7,164.65	\$0.00

Requester's Position

"Per EOB received CPT code 29888 was not paid correctly per TX work comp fee schedule. According to TX Workers Compensation Fee Schedule the expected reimbursement for CPT code 29888 is \$15,697.30."

Amount in Dispute: \$7,164.65

Respondent's Position

"Our position is that no additional payment is due."

Response Submitted by: Texas Mutual

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 fee guidelines for outpatient hospital services.

Adjustment Reasons

The insurance carrier reduced or denied payment for the disputed services with the following claim adjustment codes:

- P12 – WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
- 768 - REIMBURSED PER O/P FG AT 130%. SEPARATE REIMBURSEMENT FOR IMPLANTABLES (INCLUDING CERTIFICATION) WAS REQUESTED PER RULE 134.403(G).
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- W3 & 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- DC4 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION.

Issues

1. What rules apply to the reimbursement of the service in dispute?
2. Have the services in dispute been previously reimbursed?
3. Is the requester entitled to additional reimbursement?

Findings

1. This Medical Fee Dispute Resolution (MFDR) request involves outpatient hospital facility services in which separate reimbursement for surgical implantable items was requested on the medical bill.

DWC finds that 28 TAC §134.403 applies to the reimbursement of the services in dispute.

28 TAC §134.403(e) states in pertinent part, "Regardless of billed amount, reimbursement shall be: ... (2) if no contracted fee schedule exists 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 following minimal modifications shall be applied.

(1) 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."

Per 28 TAC §134.403 (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."

2. A review of the submitted explanation of benefits (EOB) dated January 14, 2025, finds that the insurance carrier allowed a total amount of \$17,128.05 reimbursement to the requester, for outpatient surgical facility charges rendered on the disputed date of service. This reimbursement amount included \$8,595.40 separate reimbursement for surgical implant products and \$8,532.65 comprehensive reimbursement for the disputed CPT code 29888.
3. The requester is seeking additional reimbursement in the amount of \$7,164.65 for a surgical procedure billed under the disputed CPT code 29888. On the same date of service, the medical bill included a request for separate reimbursement of surgical implantables, which have been previously reimbursed and are not in dispute. DWC finds that CPT code 29888 is the only procedure code in dispute for services rendered on November 20, 2024. Therefore, this is the only procedure code to be reviewed in this MFDR process.

DWC Rule 28 TAC §134.403 (d), which applies to the services in dispute, 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).

The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the unadjusted labor portion. This unadjusted labor portion is multiplied by the facility wage index to find the adjusted labor amount. The non-labor amount is determined when the APC payment rate is multiplied by 40%. Finally, the sum of the adjusted labor amount and the non-labor amount determines the Medicare specific amount.

**Note: Medicare wage index factors are effective for the Medicare fiscal year rather than the calendar year. Accordingly, Medicare revises wage index factors annually to be effective October 1st of each year. Therefore, for this disputed date of service, November 20, 2024, the FY 2025 wage index is applicable to calculation of the MAR.*

A review of the submitted medical bill in accordance with 28 TAC §134.403 and the applicable fee guidelines are shown below.

- Procedure code 29888 has status indicator J1, for outpatient comprehensive packaging.
- This code is assigned to APC 5114. The OPSS Addendum A payment rate is \$6,816.33.
- The OPSS Addendum A payment rate of \$6,816.33 is multiplied by 60% for an unadjusted labor amount of \$4,089.798.
- The unadjusted labor amount is multiplied by the applicable fiscal year facility wage index, in this case, 0.9256, for an adjusted labor amount of \$3,785.517.
- The non-labor portion is 40% of the APC rate, or \$2,726.532.
- The sum of the adjusted labor amount and the non-labor portion = \$6,512.049.
- Thus, the Medicare facility specific amount is \$6,512.049.
- The facility provider requested separate reimbursement for implantable items on the medical bill. Therefore, in accordance with 28 TAC §134.403, the Medicare facility specific amount is multiplied by 130% for a MAR of \$8,465.66 for CPT code 29888 rendered on November 20, 2024.
- The insurance carrier previously paid \$8,532.65 for CPT code 29888 rendered on the disputed date of service.
- Additional reimbursement is not recommended.

DWC finds that the requester is not entitled to additional reimbursement for CPT code 29888 rendered on November 20, 2024.

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 additional reimbursement in the amount of \$0.00 for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July 2, 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.