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
Arlington Orthopedic and Spine Hospital

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-25-2745-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
July 1, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 7, 2025	29827	$3,791.13	$3,791.12
	Total	$3,791.13	$3,791.12

Requester's Position

The requester submitted a document titled "Reconsideration" dated June 18, 2025 that states, "Per EOB received CPT code 29827 was not paid correctly per TX work comp guidelines."

Supplemental response submitted August 8, 2025

"…payment was received in the amount of $91.57 and balance of $3,699.56 still owed. Please continue with dispute."

Amount in Dispute: $3,791.13

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: We have escalated the bills in question for manual review to determine if additional monies are owed."

Supplemental response submitted July 30, 2025

"The bill(s) in question was/were escalated and a review completed. Our bill audit company has determined that additional monies are owed in the amount of $3,791.13. Interest in the amount of $91.57 has been added. Attached are an update copy of the Explanation of Benefits and payment summaries for your records."

Response submitted by: Gallagher Bassett

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

- 28 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.
- 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
- 28 TAC §134.403 sets out the rules and fee guidelines for outpatient hospital services.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- N45 – Payment based on authorized amount.
- TX350 – Bill has been identified as a request for reconsideration or appeal.
- TX618 – 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.

Issues

1. Did the insurance carrier support payment at fee guideline allowable?
2. What is the rule applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking payment of outpatient hospital charges rendered on January 7, 2025. The insurance carrier amended their original payment amount of $9,858.54 to state, "Our bill audit company has determined that additional monies are owed in the amount of $3,791.13…"

   The information submitted indicates a recommendation of $3791.13 but insufficient evidence was found to support a method of payment or a date this recommended amount was paid. The requester confirmed receipt of the interest payment but not the recommended amount. The services in dispute will be reviewed per applicable fee guideline.

2. 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 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)(1)(A) 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;

   (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 documentation found no evidence of a contract and the submitted medical bill did not contain a request for separate implant reimbursement.

   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 29827 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 $7,143.73 multiplied by 60% for an unadjusted labor amount of $4,286.24, in turn multiplied by facility wage index 0.9256 for an adjusted labor amount of $3,967.34.

The non-labor portion is 40% of the APC rate, or $2,857.49.

The sum of the labor and non-labor portions is $6,824.83.

The Medicare facility specific amount is $6,824.83 multiplied by 200% for a MAR of $13,649.66.

3. The total recommended reimbursement for the disputed services is $13,649.66. The insurance carrier paid $9,858.54. The amount due is $3,791.12. 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 Arlington Orthopedic and Spine Hospital has established that additional reimbursement $3,791.12 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that Old Republic Insurance Company must remit to Arlington Orthopedic and Spine Hospital $3,791.12 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	September 25, 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.