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

**Respondent Name**
Employers Preferred Insurance

**MFDR Tracking Number**
M4-25-2794-01

**Carrier's Austin Representative**
Box Number 04

**DWC Date Received**
July 7, 2025

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| February 11, 2025 | 24366 | $2,800.05 | $2,800.05 |

## Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a document titled, "Reconsideration" dated June 18, 2027 that states, "Per EOB received, CPT code 24366 was not paid correctly per TX work comp fee schedule."

**Amount in Dispute:** $2,800.05

## Respondent's Position

"After review this bill has been determined that no additional allowance is due. Bill has been processed correctly previously."

**Response submitted by:** StrataCare

## 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:

- W3 – Bill is a reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 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.
- P12 – (no description provided)
- 97 – (no description provided)

Issues

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

Findings

1. The requester is seeking payment of outpatient hospital charges rendered on February 11, 2025. The insurance carrier reduced the billed amount on the original explanation of benefits with adjustment codes P12 and 97 however, no description of the adjustment codes was provided.

   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) 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; 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 24366 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 5115. The OPPS Addendum A rate is $12,866.82 multiplied by 60% for an unadjusted labor amount of $7,720.09, in turn multiplied by facility wage index 0.9256 for an adjusted labor amount of $7,145.72.

  The non-labor portion is 40% of the APC rate, or $5,146.73.

  The sum of the labor and non-labor portions is $12,292.45.

  The Medicare facility specific amount is $12,292.45 multiplied by 200% for a MAR of $24,584.90.

2. The total recommended reimbursement for the disputed services is $24,584.90. The insurance carrier paid $21,784.84. The requestor is seeking additional reimbursement of $2,800.05. 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 Arlington Orthopedic and Spine has established that additional reimbursement of $2,800.05 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 Employers Preferred Insurance must remit to Arlington Orthopedic and Spine $2,800.05 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 | August 28, 2025<br>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.