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
Baylor Orthopedic and Spine

Respondent Name
Safety National Casualty Corp

MFDR Tracking Number
M4-25-3134-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 28, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 22 – 23, 2025	23472	$24,509.56	$24,547.32
January 22 – 23, 2025	82948	$6.30	
January 22 – 23, 2025	85018	$2.96	
January 22 – 23, 2025	85014	$2.96	
January 22 – 23, 2025	82948	$6.30	
January 22 – 23, 2025	80048	$10.58	
January 22 – 23, 2025	36415	$3.75	
January 22 – 23, 2025	82947	$4.91	
	5	$24,547.32	$24,547.32

Requester's Position

"Please find the enclosed claim denied based on extent. Please also review the enclosed coding note & the Gallagher EOB. It appears that Gallagher has entered the DX codes incorrect which has caused the denial. If you review the UB as well as out coding notes, the primary DX is (redacted). This is also the DX on the auth. We have requested that Gallagher review this. According to the reps at Gallagher this was recommend for payment 06/10/25. ...the adjuster has not released that payment & will not return any voicemail left for her regarding the issue. We respectfully request the divisions assistance with this matter."

Amount in Dispute: $24,547.32

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. We will provide a supplemental response once the bill auditing company has finalized their review."

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.
- DWC Rule TAC §133.10 sets out the billing requirements for requesting separate implant reimbursement.
- 28 TAC §124.2 – sets out requirements of carrier notifications
- 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:

- 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- 219 – Based on extent of injury.
- 00663 – Reimbursement has been calculated based on the state guidelines.
- ZK10 – Resolution Manager denial.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 247/B13 – A payment or denial has already been recommended for this service.

Issues

1. Did the insurance carrier submit required PLN notice?

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

Findings

1. The submitted explanation of benefits contained denial 219 – "Based on extent of injury".

   DWC Rule 28 TAC §133.307(d)(2)(H) requires that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

   DWC Rule 28 TAC §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

   Review of the submitted information finds no copies, as required by Rule §133.307(d)(2)(H), of any PLN-11 or PLN 1 notices issued in accordance with Rule §124.2. The insurance carrier's denial reason is therefore not supported.

   Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of extent of injury, the respondent has waived the right to raise such issues during dispute resolution.

   Consequently, the division concludes there are no outstanding issues of compensability, extent, or liability for the injury. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

2. The requester is seeking payment of outpatient hospital charges rendered on January 22 – 23, 2025. The insurance carrier denied the charges based on extent of injury and workers compensation fee schedule. As stated above the extent of injury issue is waived due to non-adherence to notification requirement.

   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.

DWC Rule TAC §133.10 (QQ) states, "remarks (UB-04/filed 80) is required when separate reimbursement for surgically implanted devices is requested.

Review of the submitted UB-04 found no request for separate implant reimbursement was made, the rules and fee guidelines associated with implants do not apply to this medical bill. The disputed charges will be reviewed and fees calculated for outpatient hospital services when separate reimbursement of implants is **NOT** requested.

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 23472 has a status indicator of J1. This code is assigned APC 5116. The OPPS Addendum A rate is $18,390.05 multiplied by 60% for an unadjusted labor amount of $11,034.03, in turn multiplied by facility wage index 0.9256 for an adjusted labor amount of $10,213.10.

  The non-labor portion is 40% of the APC rate, or $7,356.02.

  The sum of the labor and non-labor portions is $17,569.12.

  The Medicare facility specific amount is $17,569.12 multiplied by 200% for a MAR of $35,138.24.
- Procedure code 82948 has a status indicator of Q4 and is packaged into primary procedure.
- Procedure code 85018 has a status indicator of Q4 and is packaged into primary procedure.
- Procedure code 85014 has a status indicator of Q4 and is packaged into primary procedure.
- Procedure code 82948 has a status indicator of Q4 and is packaged into primary procedure.
- Procedure code 80048 has a status indicator of Q4 and is packaged into primary procedure.
- Procedure code 36415 has a status indicator of Q4 and is packaged into primary procedure.

- Procedure code 82947 is packaged into primary procedure.

3. The total recommended reimbursement for the disputed services is $35,138.24. The requestor is seeking additional reimbursement of $24,547.32. 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 requester is entitled to additional reimbursement for the disputed services. It is ordered that Safety National Casualty Corp must remit to Baylor Orthopedic & Spine Hospital $24,547.32 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		October 8, 2025
Signature	Medical Fee Dispute Resolution Officer	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.