TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Arlington Orthopedic and Spine Hospital

Respondent Name
Standard Fire Insurance Co

MFDR Tracking Number
M4-25-3187-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
August 5, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 24, 2025	27814	$497.39	$497.38

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a document titled, "Reconsideration" dated July 30, 2025 that states, "Per EOB, CPT code 27814 was not paid correctly per Tx work comp guidelines. According to TX Workers Compensation Fee Schedule surgical code should be reimbursed at 200% GARR."

Amount in Dispute: $497.39

Respondent's Position

"The Carrier has reviewed the documentation and contends the Provider has been reimbursed at the appropriate Maximum Allowable Reimbursement amount per the applicable Division-adopted fee schedule for the admission and implants. No additional reimbursement is warranted."

Response submitted by: Travelers

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:

- 97 – The benefit for this service is included in the payment/allowance for another
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 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.

Issues

1. Did the requester indicate separate implant reimbursement?
2. What is the rule applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requester submitted a request to MFDR for outpatient hospital services. Review of the submitted medical bill found in box 80, "Reimbursement claim at 130%, with a separate amount for implants.

   DWC Rule TAC §134.403(g) states, "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." The submitted documentation with this claim did not include a manufacturers invoice to support the cost. The disputed charges will

be reviewed and fees calculated for outpatient hospital services when separate reimbursement of implants per applicable fee guideline when implants are not supported.

2. The requester is seeking additional payment of outpatient hospital charges rendered on April 24, 2025. 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 27814 has status indicator J1, for procedures paid at a comprehensive rate. 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 $13,152.28. The amount due is $497.38. 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 Arlington Orthopedic and Spine has established that additional reimbursement of $497.38 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 Standard Fire Insurance Company must remit to Arlington Orthopedic and Spine Hospital $497.38 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 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.