



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Doctors Hospital at Renaissance

Respondent Name

McAllen ISD

MFDR Tracking Number

M4-25-3264-01

Carrier's Austin Representative

Box Number 29

DWC Date Received

August 13, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 7, 2025	N438922100107ML	\$0.00	\$0.00
January 7, 2025	AN AIRWAY 90MM	\$0.00	\$0.00
January 7, 2025	DRESSING ABD PAD 8" X 10"	\$0.00	\$0.00
January 7, 2025	C1900	\$0.00	\$0.00
January 7, 2025	C1713	\$0.00	\$0.00
January 7, 2025	C1763	\$0.00	\$0.00
January 7, 2025	84703	\$0.00	\$0.00
January 7, 2025	27428	\$15,226.97	\$15.25
January 7, 2025	29881	\$1,886.34	\$0.00
January 7, 2025	ANESTEHSIA GEN LEVEL-1	\$0.00	\$0.00
January 7, 2025	J1596	\$0.00	\$0.00
January 7, 2025	J3010	\$0.00	\$0.00
January 7, 2025	J3370	\$0.00	\$0.00
January 7, 2025	J1885	\$0.00	\$0.00
January 7, 2025	J1100	\$0.00	\$0.00
January 7, 2025	J2405	\$0.00	\$0.00
January 7, 2025	J2003	\$0.00	\$0.00
January 7, 2025	J0665	\$0.00	\$0.00
January 7, 2025	J2710	\$0.00	\$0.00

January 7, 2025	J2250	\$0.00	\$0.00
January 7, 2025	J2795	\$0.00	\$0.00
January 7, 2025	J2704	\$0.00	\$0.00
January 7, 2025	J1171	\$0.00	\$0.00
January 7, 2025	A9720	\$0.00	\$0.00
January 7, 2025	RECOVERY ROOM 1 ST HOUR	\$0.00	\$0.00
January 7, 2025	96374	\$0.00	\$0.00
Total		\$3,214.17	\$15.25

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration that states, "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: \$3,214.17

Respondent's Position

The Austin carrier representative for McAllen ISD is Dean G Pappas Law Firm LLC. The representative was notified of this medical fee dispute on September 8, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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:

- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation.
- 975 – This line item was reviewed using the Fair Health Charge Benchmark Database Module based on the provider geographic area.
- J49 – The allowance for this line has been summed with other allowances on the bill and re-distributed evenly:
- 370 – This hospital outpatient allowance was calculated according to the APC Rate, plus a markup.
- 615 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- 97 – The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 360 – Allowance for this procedure was made at the usual and customary amount for this geographic area.
- 617 – This item or service is not covered or payable under the Medicare outpatient fee schedule.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- P5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What services are in dispute?
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 made a payment of \$24,148.13 on March 14, 2025. The payment amount was reduced based on packaging and fee schedule amounts. The codes 27428 and 29881 are the only codes that indicate an amount in dispute on the submitted DWC060. These code will be reviewed per applicable fee guidelines.

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: 200 percent;

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 27428 has a status indicator of J1 and 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 0.8983 for an adjusted labor amount of \$6,934.96.

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

The sum of the labor and non-labor portions is \$12,081.69.

The Medicare facility specific amount is \$12,081.69 multiplied by 200% for a MAR of \$24,163.38.

- Procedure code 29881 also has a status indicator of J1. Applicable Medicare payment policy found at <https://www.cms.gov/files/document/integocespecsv160r1508-1pdf> Appendix L, (3), (i) states, "If multiple comprehensive procedures are present, select the primary J1 procedure based on the highest rank." Review of Addenda J1 found the ranking of code 27428 is 187. The ranking of code 29881 is 2,058. Code 27428 is the highest ranked J1 procedure and is the only code that receives payment.

3. The total recommended reimbursement for the disputed services is \$24,163.38. The insurance carrier paid \$24,148.13. The amount due is \$15.25. 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 McAllen ISD must remit to Doctor’s Hospital at Renaissance \$15.25 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

October 28, 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.