



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Baylor Orthopedic and Spine Hospital

Respondent Name

Safety National Casualty Corp

MFDR Tracking Number

M4-25-3365-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

August 21, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 24, 2024	29827	\$2948.38	\$2948.38
Total		\$2948.38	\$2948.38

Requester's Position

"At this time we are requesting that this claim paid in accordance with the 2024 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: \$2948.38

Respondent's Position

"Our initial response to the above referenced medial 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 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
- [28 TAC §133.10](#) sets out the requirements of requesting implant reimbursement.
- [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:

- 45 – Charge exceeds fee schedule /maximum allowable or contracted/legislated fee arrangement.
- N130 – Consult plan benefit documents/guidelines for information about restrictions for this service.
- N45 - Payment based on authorized amount.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- TX618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- XXU03 – The billed service was reviewed by UR and authorized.
- TX350 – Bill has been identified as a request for reconsideration or appeal.
- TX353 – This charge was reviewed according to the submitted invoice and documentation.
- 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 requester seek separate implant reimbursement?
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 October 24, 2024. The submitted explanation of benefits indicated payment made on codes C1713 and C1889.

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.

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) 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 29827 is assigned APC 5114. The OPPS Addendum A rate is \$6,816.33 multiplied by 60% for an unadjusted labor amount of \$4,089.80, in turn multiplied by facility wage index 0.9256 for an adjusted labor amount of \$3,785.52.

The non-labor portion is 40% of the APC rate, or \$2,726.53.

The sum of the labor and non-labor portions is \$6,512.05.

The Medicare facility specific amount is \$6,512.05 multiplied by 200% for a MAR of \$13,024.10.

3. The total recommended reimbursement for the disputed services is \$13,024.10. The insurance carrier paid \$9,501.82. The requestor is seeking additional reimbursement of \$2,948.38. 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 requestor has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Safety National Casualty Corp must remit to Baylor Orthopedic and Spine Hospital \$2,948.38 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

October 8, 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.