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 Surgical Hospital at Trophy Club

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-26-0532-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
October 27, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 12, 2025	27096	$5,292.00	$0.00

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a copy of a document titled "Reconsideration" dated October 16, 2025 that states, "Per EOB received CPT code 27096 denied for payment due to being invalid code. Please note surgical code 27096 was authorized for treatment under Precert# 6760536. We ask that you reprocess and remit payment per TX work comp guidelines."

Amount in Dispute: $5,292.00

Respondent's Position

"CPT 27096 has a status indicator of 'B' meaning it is not recognized by OPPS and is not covered for facility claims. Our position is that no payment is due."

Response submitted by: Texas Mutual

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:

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 714 – Accurate license, CPT/HCPCS, NDC 3, dates, units, days supply, modifiers are required. Submit corrections w/I 95 days from DOS.
- CAC-W3/350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- DC4 – No additional reimbursement allowed after reconsideration.

Issues

1. What is the rule applicable to reimbursement?

Findings

1. The requester is seeking payment of code 27096 rendered on March 12, 2025 as part of outpatient hospital service. The insurance carrier states in their position statement no payment was made based on the submitted code.

   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.

   DWC Rule 28 TAC §134.403 (b) (3) states, Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise.

(3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

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).

Review of the applicable Addenda B for the disputed date of service found code 27096 has a status indicator of "B" which is defined as, "Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type."

Based on the applicable Medicare payment policy for the code submitted, the insurance carrier's denial is supported. No payment 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 not established that reimbursement of $5,292.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		November 13, 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.