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

General Information

Requester Name

Doctors Hospital at Renaissance

Respondent Name

AIU Insurance Co

MFDR Tracking Number

M4-26-0541-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

October 27, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
March 27, 2025	27792	$4,687.68	$4,687. 68
March 27, 2025	27766	$6,696.68	$0.00
March 27, 2025	All others	$0.00	$0.00
	Total	$11,384.36	$4,687.68

Requester's Position

Excerpt from Reconsideration dated June 16, 2025, "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: $11,384.36

Respondent's Position

"Our initial response to the above refenced medical fee dispute resolution is as follows: We have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted By: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code Section 413.031 and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section 133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section 134.403 sets out the guidelines for outpatient hospital services.

Adjustment Reasons

- 197-4 Pre-authorization/authorization/notification absent.
- 252 – An attachment /other documentation is required to adjudicate this claim/service.
- 97-3 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- M127 – Missing patient medical record for this service.
- MA27 – Missing/incomplete/invalid entitlement number or name shown on the claim.
- MA30 – Missing/incomplete/invalid type of bill.
- N179 – Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
- P12-5 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with the TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What is DWC considering in this medical fee dispute?
2. Did the insurance carrier support the denials shown above?
3. What rule is applicable to reimbursement?
4. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking additional reimbursement of two surgical procedures rendered on March 27, 2025 in an outpatient hospital setting in the amount of $11,384.36. All other items listed on the DWC060 have an amount in dispute of $0.00. The insurance carrier made a payment of $8,705.68 on code 27792. The remaining amount in dispute is

$11,384.36.

2. The explanation of benefits submitted with this request for MFDR indicates lack of required prior authorization and missing documents. However, the insurance carrier did not supplement their response to the request for MFDR in support of the reductions made on the disputed charges. As a payment was made, the MAR based on the applicable fee guideline is shown below.
3. The DWC Rule applicable to the reimbursement of outpatient hospital services is found in 28 TAC Section 134.403(d) that 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).

   28 TAC Section 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.

   28 TAC Section 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 27792 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. 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 0.8983 for an adjusted labor amount of $3,850.33.

The non-labor portion is 40% of the APC rate, or $2,857.49.
The sum of the labor and non-labor portions is $6,707.82.
The Medicare facility specific amount is $6,707.82 multiplied by 200% for a MAR of $13,415.64.

- Procedure code 27766 has status indicator J1, for procedures paid at a comprehensive rate. The Medicare payment policy applicable to J1 comprehensive procedures allows payment for only the highest rank procedure. Rankings of each code is found at www.cms.gov, Addenda J. Code 27792 has a ranking of 596. Code 27766 has a ranking of 671. Therefore, Code 27792 is the highest ranked and is the only code payable.

4. The total recommended reimbursement for the disputed services is $13,415.64. The insurance carrier paid $8,705.68. The amount requested for Code 27792 is $4,687.68. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence requester and the respondent presented 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 Sections 413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that AIU Insurance Co must remit to Doctor's Hospital at Renaissance $4,687.68 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 29, 2026 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section 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 800-252-7031, option three 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section 141.1(d).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.