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
Texas Spine & Joint Hospital

Respondent Name
Old Republic

MFDR Tracking Number
M4-26-0583-01

Insurance Carrier's Austin Representative
BOX 44 White Espey PLLC

DWC Date Received
October 30, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
March 14, 2025	72020-TC	$832.00	$0.00
March 14, 2025	63030-RT	$20,226.00	$13,554.52
	Total	$21,058.00	$13,554.52

Requester's Position

"The MedInsights authorization letter shows that approval was granted on 2/27/25 after peer review, and an authorization rage of 02/27/25 to 5/27/25 was given, authorization no. 8233712. The surgery took place on 3/14/25, within the granted authorization range. The Hospital billed for the approved treatment."

Amount In Dispute: $21,058.00

Respondent's Position

"Our initial response to the above referenced 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.
3. 28 TAC Section 134.600 sets out the requirements of prior authorization.

Adjustment Reasons

1. 197-5 – Precertification/authorization/notification/pre-treatment absent.
2. TX930 – Pre-authorization required, reimbursement denied.

Issues

1. What is DWC considering in this medical fee dispute?
2. Did the requester support prior authorization sought and obtained?
3. What rule is applicable to reimbursement?
4. Is the requester entitled to reimbursement?

Findings

1. The requester is seeking reimbursement of outpatient hospital services rendered on March 14, 2025. The amount shown in dispute is $21,058.00. The insurance carrier made no payment based on lack of prior authorization.

2. 28 TAC Section 134.600 sets out the requirements of prior authorization and states in (p)(2) states in pertinent parts, "Non-emergency health care requiring preauthorization includes: outpatient surgical or ambulatory surgical services…"

   Review of the information submitted with this request for MFDR found, Texas Utilization Review, Preauthorization Approval, date February 27, 2025 via Preauthorization Number: # 8233712. This authorization approved code 63030 with a date range from February 27, 2025 through May 27, 2025. The insurance carriers denial is not supported, the reviewed information supports the required prior authorization was sought, obtained and valid at the time of service.

3. 28 TAC Section 134.403 states

   - Procedure code 63030 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 0.9145 for an adjusted labor amount of $3,919.77.

The non-labor portion is 40% of the APC rate, or $2,857.49.

The sum of the labor and non-labor portions is $6,777.26.

The Medicare facility specific amount is $6,777.26 multiplied by 200% for a MAR of $13,554.52.

- Procedure code 72020 has a status indicator of Q1 and is packaged into the primary comprehensive procedure.

4. The total recommended reimbursement for the disputed services is $13,554.52. The insurance carrier paid $0.00. The amount due is $13,554.52. 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 reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that Old Republic Insurance Co must remit to Texas Spine & Joint Hospital $13,554.52 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

		January 29, 2026
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 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.