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

General Information

Requester Name
TOPS Specialty Hospital

Respondent Name
Texas Municipal League Intergovernmental

MFDR Tracking Number
M4-26-0620-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 3, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 21, 2024	29807	$3,618.54	$0.00

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" dated August 26, 025 that states, "The billed charges were not paid correctly per TX work comp guidelines. Please note that separate reimbursement was not requested in Box 80 of UB-04 from for implant and surgical code 29807 should be reimbursed at 200% GARR."

Amount in Dispute: $3,618.54

Respondent's Position

"The provider's initial medical bill included a request for separate reimbursement for implants. However, the implant invoices were not included in the bill. Accordingly, the provider's bill was denied based upon a lack of the production of the implant invoices. The carrier received a subsequent bill with the implant invoices. Based upon those documents, the carrier reimbursed the provider $9,864.43. A third bill was submitted, although it did not request separate reimbursement for the implants. The provider has already been paid for the implant invoices. No additional monies are owed."

Response submitted by: Flahive, Ogden & Latson

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

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.403 sets out the reimbursement guidelines for implants utilized during outpatient surgical services.

Denial Reasons

- 16 – Claim/service lacks information or has submission/billing error(s),
- 205 – This charge was disallowed as additional information/definition is required to clarify service/supply rendered.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – Bill is a reconsideration or appeal

Issues

1. Did the health care provider request separate reimbursement of implants on the original bill?
2. What is the rule applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking additional payment of outpatient hospital services rendered on November 21, 2024. The requester states in their document titled "Reconsideration" separate reimbursement of implants was not requested. Documentation submitted by the respondent (page 3 of 24) finds the original medical bill with a creation date of January 23, 2025. This medical bill did contain a request for implant reimbursement in box 80. The documentation from the respondent also contained a medical bill (page 6 of 24) with a creation date of April 15, 2025. This medical bill was created 95 days after the date of service and will not be considered in this review. The carrier's adjudication of the medical bill created on January 23, 2025 fee calculation 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 exits 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; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent. Review of the submitted medical bill found a request for implants was made. The Medicare facility specific reimbursement amount will be multiplied by 130 percent.

DWC Rule 28 TAC §134.403 (g) states, Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

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 is shown below.

- Procedure code 29807 This code 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 0.9817 for an adjusted labor amount of $4,014.96.

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

  The sum of the labor and non-labor portions is $6,741.49.

The Medicare facility specific amount is $6,741.49 multiplied by 130% for a MAR of $8,763.94.

- The submitted medical bill and itemized statement found the following implant was submitted for separate reimbursement.
    - "Anchor Y-Knot pro flex" as identified in the itemized statement with a cost per unit of $436.00 at 2 units, for a total cost of $872.00. The total net invoice amount (exclusive of rebates and discounts) is $872.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $87.20. The total recommended reimbursement amount for the implantable items is $959.20.

3. The total recommended reimbursement for the disputed services is $9,722.84. The insurance carrier paid $9,864.43. Additional payment is not recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester 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 additional reimbursement is due.

Order

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

Authorized Signature

		November 21, 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.