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

General Information

Requester Name
North Central Surgical Hospital

Respondent Name
Utica Mutual Insurance Company

MFDR Tracking Number
M4-26-0700-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
November 12, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 4, 2025	111-278	$6,149.94	$1,354.00

Requester's Position

"In accordance to the worker compensation guidelines the invoice should be processed and paid per the IPPS Pricer Calculations for the DRG times 108%. Also, implant invoices should be reimbursed at manual cost plus 10%."

Amount in Dispute: $6,149.94

Respondent's Position

"The medical bill in question was first received by Utica on March 31, 2025, processed and paid on April 2, 2025. Re-evaluations were completed on June 11 2025, and October 9, 2025, Payment has been paid in accordance with the Fee Schedule Guidelines and based on the CPTs and documentation the provider submits. It is the Respondent's position that the provider is not entitled to further payment."

Response Submitted by: Utica National Insurance Group

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) §134.404 sets out the acute care hospital fee guideline for inpatient services.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim amount and must not duplicate provider adjustment amounts (payment and contractual.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- Note: No additional allowance is recommended. Per TX guidelines implant reimbursement limited to cost – 10% up to $1,000.00.
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Issues

1. Is the respondent's position supported?

2. What rule is applicable to reimbursement?

3. Is requester entitled to additional reimbursement?

Findings

1. This dispute regards inpatient hospital facility services with payment subject to DWC Rule 28 TAC §134.404(f), requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Inpatient Prospective Payment System (IPPS) formulas and factors, as published annually in the Federal Register, with modifications set forth in the rules. Medicare IPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

The division calculates the Medicare facility specific amount using Medicare's *Inpatient PPS PC Pricer* as a tool to efficiently identify and apply IPPS formulas and factors. This software is freely available from www.cms.gov.

Note: the "VBP adjustment" listed in the *PC Pricer* was removed in calculating the facility amount for this admission. Medicare's Value-Based Purchasing (VBP) program is an initiative to improve quality of care in the Medicare system. However, such programs conflict with Texas Labor Code sections 413.0511 and 413.0512 regarding review and monitoring of health care quality in the Texas workers' compensation system. Rule §134.404(d)(1) requires that specific Labor Code provisions and division rules take precedence over conflicting CMS provisions for administering Medicare. Consequently, VBP adjustments are not considered in determining the facility reimbursement.

Review of the submitted documentation finds that separate reimbursement for implantables was requested; for that reason, the MAR is calculated according to §134.404(f)(1)(B).

2. Per §134.404(f)(1)(B), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 108%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov.

   Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 402. The services were provided at North Central Surgical Center. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $26,806.03. This amount multiplied by 108% results in a MAR of $28,950.51.

3. Additionally, the provider requested separate reimbursement of implantables. Per §134.404(g):

   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.

   Review of the submitted documentation finds that the separate implantables include:

   - "Screw Bone 4675125 25mm" as identified in the itemized statement and labeled on the invoice as "Screw Bone 4675125 25mm 4675125" with a cost per unit of $270.00;
   - "Screw 98716250 Var 6.5x2" as identified in the itemized statement and labeled on the invoice as "Screw 98716250 Var 6.5x25.0mm 98716250" with a cost per unit of $150.00 at 3 units, for a total cost of $450.00;
   - "Screw 6.5 X 40mm Voyager" as identified in the itemized statement and labeled on the invoice as " Screw 6.5 X 40mm Voyager Screw " with a cost per unit of $1,050.00 at 2 units, for a total cost of $2,100.00;
   - "Screw 5.5mm / 6.0mm Sole" as identified in the itemized statement and labeled on the invoice as "Screw 5.5mm/6.0mm Solera Voyager 6540530" with a cost per unit of $65.00 at 4 units, for a total cost of $260.00;

- “Rod 5.5mmx40mm COCR 654" as identified in the itemized statement and labeled on the invoice as " Rod 5.5mmx40mm COCR 654000040" with a cost per unit of $500.00;
- “Screw 6.5x45 5585001654” as identified in the itemized statement and labeled on the invoice as “Screw 6.5x45 55850016545” with a cost per unit of $1,050.00 at 2 units, for a total cost of $2,100.00;
- “Putty Easpack Magnetos 5" as identified in the itemized statement and labeled on the invoice as "Putty Easpack Magnetos 5cc 1-2mm USA 703-051-US" with a cost per unit of $1,785.00;
- “Spacer MD TI 12dg 37x29x" as identified in the itemized statement and labeled on the invoice as "Spacer MD TI 12dg 37x29x16mm 46511216" with a cost per unit of $6,975.00;
- “Plate 9873133 3-Hole 33m" as identified in the itemized statement and labeled on the invoice as " Plate 9873133 3-Hole 33mm 9873133" with a cost per unit of $2,300.00; two individual charges for same item were listed on itemized statement, however only one was invoiced. Recommended reimbursement is $2,300.00.
- "Infuse Kit Bone Graft X" as identified in the itemized statement no invoice was found to allow the reimbursement calculation. Recommended reimbursement is $0.00.

The total net invoice amount (exclusive of rebates and discounts) is $16,740.00. 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 $1,674.00. The total recommended reimbursement amount for the implantable items is $18,414.00.

4. The total recommended payment for the services in dispute is $47,364.51. The amount previously paid by the insurance carrier of $46,010.51 leaves an amount due to the requester of $1,354.00. The requester is seeking $6,149.94. The amount recommended is $1,354.00.

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 established that additional reimbursement of $1,354.00 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. It is ordered that Utica Mutual Insurance Company must remit to North Central Surgical Hospital $1,354.00 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	December 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 electronico CompConnection@tdi.texas.gov.