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

General Information

Requester Name

Arlington Orthopedic and Spine

Respondent Name

Dallas ISD

MFDR Tracking Number

M4-26-0939-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

December 1, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
June 4, 2025	25608	$556.69	$0.00
	Total	$556.69	$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 November 6, 2025 that states, "Per EOB received, CPT code 25608 was not paid correctly per TX work comp guidelines. Please note that separate reimbursement was not requested in Box 80 of UB-04 form. According to TX Workers Compensation Fee Schedule surgical code 25608 should be reimbursed at 200% GARR."

Amount In Dispute: $556.69

Respondent's Position

"An additional allowance of $556.69 plus interest is being recommended. At this time, we are requesting withdrawal of the dispute."

Supplemental response submitted May 6, 2026

"Please see attached EOB. The reimbursement amount of $567.44 included $10.75 in interes issued on 12/12/2025 check #161754."

Response Submitted By: Argus

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

The insurance carrier denied payment for the disputed services with the following reasons:

- W3 – Reconsideration/Appeal
- W3B – Additional payment made on reconsideration/appeal "Per MDR Findings and Decision Order
- W7 – Payment of interest/penalty to provider.
- 97H – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Service(s)/Procedure is included in the value of another service/procedure billed on the same date.
- P12UA– Workers Compensation jurisdictional fee schedule adjustment. "Medicare outpatient hospital specific reimbursement amount multiplied by 200%. DWC rule 134.403.
- P12SA – Workers Compensation jurisdictional fee schedule adjustment. "Medicare outpatient hospital specific reimbursement amount multiplied by 130%.

Issues

1. What is DWC considering in this medical fee dispute?
2. Has the supplemental payment made by the insurance carrier met the Maximum Allowable Reimbursement (MAR)?
3. Has DWC determined whether additional reimbursement is due to the requester?

Findings

1. The requester submitted to MFDR for additional reimbursement in the amount of $556.69 for cod 25608 rendered on June 4, 2025 while in an outpatient hospital setting. The insurance carrier submitted evidence of an additional payment of $567.44 on December 5, 2025. DWC will calculate the appropriate MAR based on DWC fee guidelines.

2. The fee guideline for outpatient hospital services is found in 28 TAC Section 134.403 (d) which 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 25608 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 0.9256 for an adjusted labor amount of $3,967.34.

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

The sum of the labor and non-labor portions is $6,824.83.

The Medicare facility specific amount is $6,824.83 multiplied by 200% for a MAR of $13,649.66.

3. Review of the disputed reimbursement has found the total recommended reimbursement for the disputed services is $13,649.66. The insurance carrier paid $13,660.42. Additional payment is not recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence the 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 not 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 $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 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.