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
Frisco Medical Center

Respondent Name
Employers Mutual Casualty Co

MFDR Tracking Number
M4-26-1403-01

Insurance Carrier's Austin Representative
BOX 19 Flahive Ogden & Latson

DWC Date Received
January 19, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
February 10, 2025	27698	$4,157.80	$4,157.80
	Total	$4,157.80	$4,157.80

Requester's Position

"Per Texas Administrative Code Chapter 134.403(e), Outpatient hospital services, including surgical services are reimbursable at 200% of Medicare allowable, with consideration to appropriate NCCI Policy Manual edits regardless of billed charges. Per the guidelines, the allowable for 27698 at 200% of Medicare is $13,110.80. Their payment of $8953.00 leaves an underpayment of $4,157.80."

Amount In Dispute: $4,157.80

Respondent's Position

"The provider is not entitled to additional monies."

Response Submitted By: Flahive, Ogen & Latson

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 133.10 details the requirements of billing forms and formats.

Adjustment Reasons

- 252 – An attachment other documentation is required to adjudicate this claim/service.
- 97 – Payment is included in the allowance for another service/procedure.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 252 – An attachment /other documentation is required to adjudicate this claim/service.
- W3 – In accordance with 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. Was the carrier's denial for lack of documentation for the implants supported?
3. What rule is applicable to reimbursement?
4. Has DWC found the requester is entitled to additional payment?

Findings

1. The requester is seeking additional payment of an outpatient surgical procedure rendered on February 10, 2025 in the amount of $4,157.80. The charges were reduced due to packaging, lack of documentation and workers' compensation fee schedule. These reductions are discussed below.
2. 28 TAC Section 133.10(f)(2) states, All information submitted on required paper billing forms must be legible and completed in accordance with this section... The following data content or data elements are required for a complete institutional medical bill related to Texas workers' compensation health care: (QQ) – remarks (UB/04/field 80) is required when separate reimbursement for surgically implanted devices is requested.

Review of the submitted medical bill found no request for separate implant reimbursement was made. Therefore, the insurance carrier's denial for documentation is not supported and the fee calculation will be based on fee guideline when separate implant reimbursement is not made.

3. 28 TAC Section 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).

   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 27698 has status indicator J1, for procedures paid at a comprehensive rate. All the services covered 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 0.9362 for an adjusted labor amount of $4,012.78.

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

     The sum of the labor and non-labor portions is $6,870.27.

     The Medicare facility specific amount is $6,870.27. This is multiplied by 200% for a MAR of $0.00.

4. The total recommended reimbursement for the disputed services is $13,750.54. The

insurance carrier paid $8,953.00. The requester is seeking additional reimbursement of $4,157.80. 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 Employers Mutual Casualty Co must remit to Frisco Medical Center $4,157.80 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	February 24, 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.