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

General Information

Requester Name

Baylor Surgical Hospital Trophy Club

Respondent Name

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-26-1741-01

Insurance Carrier's Austin Representative

BOX 15 Downs Stanford PC

DWC Date Received

February 19, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
March 31, 2025	82948	$6.30	$0.00
March 31, 2025	64483	$780.05	$780.05
	Total	$786.35	$780.05

Requester's Position

"At this time we are requesting that this claim paid in accordance with the 2025 Texas Workers Compensation Fee Schedule and Guidelines."

Amount In Dispute: $786.35

Respondent's Position

The Austin carrier representative for Indemnity Insurance Co of North America is Downs & Stanford. The representative was notified of this medical fee dispute on February 20, 2026.

Per 28 Texas Administrative Code §133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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

- 193 – Original payment decision is being maintained. This claim was processed properly the first time.
- 59 – Processed based on multiple or concurrent procedure rules.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers compensation jurisdictional fee schedule adjustment.

Issues

1. What is DWC considering in this medical fee dispute?

2. What rule is applicable to reimbursement?

3. Has DWC determined whether additional reimbursement is due to the requester?

Findings

1. The requester is seeking additional reimbursement of codes 82948 and 64483-50, rendered at an outpatient hospital on March 31, 2025 in the amount of $786.35.

2. The DWC Rule applicable to the reimbursement of Outpatient Hospital Services is 28 TAC Section 134.403 (d) which states, 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 82948 has a status indicator of Q4 – Packaged APC payment if billed on the same claim as a HCPC code assigned published status indicator "T". No separate payment.
- Procedure code 64483 has status indicator T. This code is assigned APC 5443. The OPPS Addendum A rate is $890.29 multiplied by 60% for an unadjusted labor amount of $534.17, in turn multiplied by facility wage index 0.9362 for an adjusted labor amount of $500.09.

  The non-labor portion is 40% of the APC rate, or $356.12.

  The sum of the labor and non-labor portions is $856.21.

  The provider billed this code with modifier 50. Bilateral procedures are paid at the rate for two units. The highest paying status indicator T code is paid at 100% for the first unit; each additional unit is paid at 50%, 856.21 x 50% = $428.10.

The APC amount is $856.21 + $428.11 = $1,284.32.

The Medicare facility specific amount is $1,284.32 multiplied by 200% for a MAR of $2,568.63.

3. The total recommended reimbursement for the disputed services is $2,568.63. The insurance carrier paid $862.21. The requestor is seeking additional reimbursement of $780.05. This amount is 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 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 Indemnity Insurance Co of North America must remit to Baylor Surgical Hospital at Trophy Club $780.05 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

		May 13, 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.