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

General Information

Requester Name

Baylor Orthopedic & Spine Hospital

Respondent Name

City of Irving

MFDR Tracking Number

M4-26-2199-01

Insurance Carrier's Austin Representative

BOX 44 White Espey PLLC

DWC Date Received

April 6, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
December 30, 2025	C1713	$0.00	$0.00
December 30, 2025	27650 RT	$2521.25	$300.42
	Total	$2521.28	$300.42

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: $251.28

Respondent's Position

"I have reviewed bill (redacted) and can advise that it is correctly pricing this bill. When implants are paid separately the markup is 130% and not 200% per Rule 134.403. It is our position that no additional reimbursement is due."

Response Submitted By: Claims Administrative Services, Inc

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 133.10 sets out the requirements for a complete medical bill.
3. 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:

- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 371 – This hospital outpatient allowance was calculated according to the OPPS payment for this service.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 790 – This charge was reimbursed in accordance to the Texas Medical fee guideline.
- 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.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the respondent's position supported?
3. What rule is applicable to reimbursement?
4. Has DWC determined whether additional reimbursement is due to the requester?

Findings

1. The requester is seeking additional reimbursement for code 27650 -RT rendered in an outpatient hospital setting on December 30, 2025 in the amount of $2521.28. While the requester included code C1713 on the submitted DWC060 the amount in dispute is $0.00. This code will not be considered in this review.

2. The respondent states in pertinent part, "..When implants are paid separately the markup is 130% and not 200%. 28 TAC 133.10(2)(QQ) states, The following content or data elements are required for a complete institutional medical bill related to Texas workers' compensation health care: remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested.

   Review of the submitted medical bill does not indicate the health care provider submitted a request for separate reimbursement of implants. The service in dispute will be reviewed per applicable fee guideline when separate reimbursement of implants is not requested.

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)(1)(A) 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: 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 27650 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.

4. The total recommended reimbursement for the disputed services is $13,649.66. The insurance carrier paid $13,349.24. The amount due is $300.42. 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 City of Irving must remit to Baylor Orthopedic & Spine Hospital Arlington $300.42 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

		May 7, 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.