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

Technology Insurance Co

MFDR Tracking Number

M4-26-2415-01

Insurance Carrier's Austin Representative

BOX 17 Downs Stanford PC

DWC Date Received

April 28, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
December 18, 2025	82948	$6.30	$0.00
December 18, 2025	24342	$3,577.92	See requested total amount
December 18, 2025	C1713	$0.00	$0.00
December 18, 2025	J1885	$0.00	$0.00
	Total	$2,272.52	$2,272.52

Requester's Position

"The attached claim not paid according to the 2025 Texas work comp Fee Schedule. We are disputing the allowed amount of the attached claim… 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: $2,272.52

Respondent's Position

"The Carrier has paid a total of $10,183.98. This amount was inclusive of the entire surgical procedure and calculated using the OPPS rate for the procedure… In conclusion, Requestor is not owed any additional reimbursement for the surgical procedure".

Response Submitted By: Downs & Stanford

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 reduced payment for the disputed services with the following reasons:

1. 790 - THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
2. 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
3. P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
4. W3 & 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL AHS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. What is DWC considering in this medical fee dispute?
2. What rules apply to the services in dispute?
3. Is the requester entitled to additional reimbursement?

Findings

1. This medical fee dispute resolution (MFDR) request involves services rendered in an outpatient facility on December 18, 2025.

   DWC notes that the total dollar amount in the "Amount in Dispute" column of the DWC Form-060 *Medical Fee Dispute Resolution Request* (DWC Form-060) does not compute with the line-item amounts in dispute. As such, DWC considers the amount in dispute to be $2,272.52 as is populated in the "Total Amount in Dispute" field of the form.

   DWC further notes that the only procedure codes showing an amount in dispute above $0.00 are procedure codes 24342 and 82948. Therefore, DWC will only consider these two procedure codes in this MFDR review.

   The insurance carrier has previously paid a total amount of $10,183.98 for services rendered on the date in dispute. This amount includes reimbursement of $1,311.31 for surgical implants. However, an examination of the submitted medical bill finds that the requester, an outpatient hospital facility, did not request separate reimbursement for surgical implants.

   The requester is seeking additional reimbursement in the total amount of $2,272.52. DWC will review the submitted documentation to determine if the requester is entitled to additional reimbursement in accordance with applicable DWC Statutes and Rules.

2. Because the services in dispute were rendered in an outpatient facility setting, DWC finds that 28 TAC Section 134.403, which sets out fee guidelines for outpatient hospital services, applies to the reimbursement of the disputed services.

   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).

   DWC Rule 28 TAC §134.403 (e) states in pertinent part, regardless of billed amount, when no specific fee schedule or contract exists, reimbursement shall be the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

   DWC Rule 28 TAC §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 following minimal modifications shall be applied. (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent…"

According to a review of the submitted medical bill, DWC finds that the requester did not request separate reimbursement for surgical implants. Therefore, the MAR for the disputed service shall be the Medicare facility specific reimbursement amount multiplied by 200 percent.

3. The requester is seeking additional reimbursement in the amount of $2,272.52 for outpatient facility charges rendered on December 18, 2025.

   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 in accordance with the applicable fee guidelines referenced above is shown below.

   - Procedure code 24342 has a status indicator of J1, for outpatient comprehensive packaging.
   - This code is assigned APC 5114. The OPPS Addendum A rate is $7,143.73 multiplied by 60% for an unadjusted labor amount of $4,286.238, in turn multiplied by facility wage index 0.9256 for an adjusted labor amount of $ 3,967.342.
   - The non-labor portion is 40% of the APC rate, or $2,857.492.
   - The sum of the adjusted labor amount and the non-labor portion is $6,824.834.
   - Therefore, the Medicare facility specific amount is $6,824.834.
   - **Separate implant reimbursement was not requested** per the submitted medical bill. Therefore, the Medicare facility specific amount is multiplied by **200%** for a MAR of $13,649.668.

- Procedure code 82948 has a status indicator of Q4, indicating that the procedure is packaged into the APC payment if billed on the same claim as a procedure code assigned status indicator "J1". Because disputed procedure code 82948 was billed on the same claim as another procedure code assigned status indicator "J1".
- DWC finds that disputed procedure code 82946 does not receive separate reimbursement.
- The total recommended reimbursement for the disputed services is $13,649.67.
- The insurance carrier paid $10,183.98.
- The requester is seeking additional reimbursement in the amount of $2,272.52. This amount is recommended.
- DWC finds that the requester is entitled to additional reimbursement in the amount of $2,272.52.

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 Technology Insurance Co. must remit to Baylor Orthopedic & Spine Hospital $2,272.52 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	May 20, 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.