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

Doctors Hospital at Renaissance

Respondent Name

Technology Insurance Co

MFDR Tracking Number

M4-26-2690-01

Insurance Carrier's Austin Representative

BOX 17 Downs Stanford PC

DWC Date Received

May 27, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
October 23, 2025	11012 F1	$5,374.82	$0.00
October 23, 2025	11760 F1	$1,157.56	$0.00
October 23, 2025	J0687	$1.78	$0.00
October 23, 2025	96374	$395.66	$0.00
October 23, 2025	All others	$0.00	$0.00
	Total	$3,885.323 [sic]	$0.00

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a document titled, "Request for Reconsideration" dated May 11, 2026 that states, "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount In Dispute: $3,885.32

Respondent's Position

"…Requestor is not owed any additional reimbursement for the surgical procedure."

Response Submitted By: Downs & Stanford PC

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:

- 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.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 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.
- 617 – This item or service is not covered or payable under the Medicare outpatient fee schedule.
- 618 – The value of this procedure is package 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.
- @PRV – Prior allowance.

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?

Findings

1. The requester is seeking additional reimbursement of outpatient hospital services rendered in October 2025 with an amount of $3,885.32 shown on the submitted DWC060. DWC will review the codes listed on the DWC060 with amounts in dispute. Those items listed with zero amount in dispute will not be considered in this review.
2. 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 11012 F1 has a status indicator of J1. However, this medical bill also contained code 26765 which is also a J1 code. The applicable Medicare policy allows for payment of only the highest ranked J1 procedure. Code 11012 has a ranking of 2,484. Code 26765 has a ranking of 2,123. Therefore, Code 26765 is the highest ranked J1 code and is the only code that is reimbursed. No payment recommended for code 11012 F1 listed on this dispute.
- Procedure code 11760 F1. This code has a status indicator of T and is packaged into the comprehensive J1 code. No separate payment recommended.
- Procedure code J0687. This code has a status indicator of K and is paid separately. The assigned APC is 0753 with an allowable of $0.95.

  The adjusted labor amount ($0.95 x 60%) = $.57 x wage index of provider 0.8983 = adjusted labor rate of $0.51.

  Non-labor portion $0.95 x 40% = $0.38.

  The provider specific allowed amount is ($0.51 + $0.38) $0.89 x 200% = $1.78.
- Procedure code 96374. This code has a status indicator of S and is packaged into the comprehensive J1 code. No separate payment is recommended.

3. DWC has reviewed the information presented during this dispute and finds no additional payment 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 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	June 23, 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.