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

Requestor Name
Metroplex Adventist Hospital

Respondent Name
Fire Insurance Exchange

MFDR Tracking Number
M4-25-1816-01

Carrier's Austin Representative
Box Number 14

DWC Date Received
April 7, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
05/17/2024	96375	$50.39	$0.00
05/17/2024	96374	$370.60	$0.00
05/17/2024	99282/25[sic]	$916.69	$0.00
	Total	$1,337.68	$0.00

Requestor's Position

The requestor submitted a document titled "Reconsideration" dated March 6, 2025 that states, "According to TX Workers Compensation Fee Schedule the expected reimbursement for DOS 5/1/2024 IS $3,139.17. Please note that Outpatient services should be reimbursed at 200% GARR."

Amount in Dispute: $1,337.68

Respondent's Position

"The bill was originally processed under bill id FWTX-37758 with a recommended allowance of $2,447.59. The bill was then reprocessed under FWTX-40602 with a recommended allowance of $2,509.62 using the methodology below, a check was issued on 4/29/2025 for the additional allowance of $53.46 under check #1642429444."

Response submitted by: Mitchell

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.403 sets out the rules and fee guidelines for outpatient hospital services.

Denial Reasons

- 350 – Bill has been identified as a request for reconsideration or appeal.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 630 – This service is packaged with other services performed on the same date and reimbursement is based on a single composite APC rate.
- 95 – Plan procedures not followed.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- J49 – The allowance for this line has been summed with other allowances on the bill and re-distributed evenly.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- U00 – There was no UR procedure/treatment request received.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- Additional allowance recommended.

Issues

1. What is the rule applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of services rendered during an outpatient emergency room visit on May 17, 2024. The insurance carrier supports payments made in the amount of $2,447.59 on October 17, 2024 and $53.46 on April 29, 2025 for a total payment of $2,509.60.

   DWC Rule 28 TAC §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)(2) states in pertinent part, regardless of billed amount, if no contracted fee schedule exits 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.

   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 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. Review of the submitted medical bill found a request for implants is not applicable.

   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 codes 70450, 74177, 71260 and 72125 (not in dispute) have a status indicator of Q3. As the criteria for composite payment is met these codes are paid under a single APC payment for composite CT scan with contrast or APC 8006. The OPPS Addendum A rate is $427.60 multiplies by 60% for an unadjusted labor amount of $256.56, in turn multiplied by facility wage index of 0.9557 for and adjusted labor amount of $245.19.

The non-labor portion is $171.04

The sum of the labor and non-labor portions is $416.23.

The Medicare facility specific amount is $416.23 multiplied by 200% for a MAR of $832.46.

- Procedure code 96375 has an unbundle relationship with code 71260. Per DWC Rule §134.403 (d) "for coding billing and reporting Texas workers' compensation participants shall apply Medicare payment policies in effect on the date of service. DWC Rule §134.403 (b)(3) defines Medicare payment policy as "reimbursement methodologies, models, and values or weights including its coding, billing and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare." No payment is recommended.

- Procedure code 96374 has an unbundle relationship with code 74177. As above, no payment is recommended.

- Procedure code 99285/25 has status indicator V, for an outpatient visit paid by APC. This code is assigned APC 5025. The OPPS Addendum A rate is $611.99 multiplied by 60% for an unadjusted labor amount of $367.19, in turn multiplied by facility wage index 0.9557 for an adjusted labor amount of $350.92.

  The non-labor portion is 40% of the APC rate, or $244.80

  The sum of the labor and non-labor portions is $595.72.

  The Medicare facility specific amount is $595.72 multiplied by 200% for a MAR of $1,191.44.

3. The total recommended reimbursement for the disputed services is $2,023.90. The insurance carrier paid $2,509.62. No additional payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent 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 §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		May 22, 2025
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 §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 1-800-252-7031, option 3 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 the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.