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

General Information

Requester Name
Midland Memorial Hospital

Respondent Name
AIU Insurance

MFDR Tracking Number
M4-25-2378-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 28, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 28, 2024	CT scan	$193.36	$193.36

Requester's Position

"Per attached documents, the authorization was appealed and ultimately approved as 'a CT is necessary to evaluate for step off. Therefore, the request be certified.'"

Amount in Dispute: $193.36

Respondent's Position

The Austin carrier representative for AIU Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on May 29, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the 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 §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

- 28 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.
- 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
- 28 TAC §134.403 sets out the rules and fee guidelines for outpatient hospital services.
- 28 TAC §134.600 which sets out the requirements of prior authorization.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005 – No addition reimbursement allowed after review of appeal/reconsideration.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Bill is a reconsideration or appeal.

Issues

1. What rules are applicable to reimbursement?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking payment for the outpatient CT scan performed on June 28, 2024. The explanation of benefits submitted with the request for MFDR affirmed the original denial. The respondent did not submit a position statement. The rules applicable to an outpatient CT scan are, DWC Rule TAC §134.600(p)(2) which states in relevant part, non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section… Review of the submitted documentation found Sedgwick certified a CT scan of (redacted) w/o contrast under Ref # 5584268.

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 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.

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.

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 73200 This code is assigned APC 5522. The OPPS Addendum A rate is $104.75 multiplied by 60% for an unadjusted labor amount of $62.85, in turn multiplied by facility wage index 0.8758 for an adjusted labor amount of $55.04.

  The non-labor portion is 40% of the APC rate, or $41.90.

  The sum of labor and non-labor portions is $96.94.

  The Medicare facility specific amount is $96.94 multiplied by 200% for a MAR of $193.88.

2. The total recommended reimbursement for the disputed services is $193.88. The insurance carrier paid $0.00. The requester is seeking $193.36. This amount 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 Medland Memorial Hospital has established that reimbursement of $193.36 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that AIU Insurance Company must remit to Methodist Memorial Hospital Midland $193.36 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 21, 2025 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.