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**
Methodist Health Systems

**Respondent Name**
Texas Mutual Insurance Co

**MFDR Tracking Number**
M4-25-2502-01

**Carrier's Austin Representative**
Box Number 54

**DWC Date Received**
June 9, 2025

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| October 29, 2024 | Radiology | $166.29 | $166.29 |

## Requester's Position

"Requesting review of compensability."

**Amount in Dispute:** $166.29

## Respondent's Position

"Texas Mutual has reviewed the DWC-60 submitted by Methodist Dallas Medical Center and has determined the DWC-60 has been submitted prior to final decision on a pending appeal request that has been received on 5/27/2025, bill reference #19386586/900000062399. The insurance carrier shall take final action on the reconsideration request within 30 days of receipt per Rule 133.250(g). At this time Texas Mutual maintains it's position until the request for reconsideration has been finalized. Our position is that no payment is due."

**Response submitted by:** Texas Mutual

## 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 Texas Administrative Code (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 §124.2 set out notification requirements.

Denial Reasons

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

- 225/16 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 892/P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 892-225 – Documentation does not support causal relationship to the compensable injury.
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT Code/Descriptions/Instructions.

Issues

1. Is the insurance carrier's denial supported?
2. Did the insurance carrier audit the medical bill within 30 days from receipt of the medical bill, 5/27/2025?
3. What is the rule applicable to reimbursement?
4. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking payment of outpatient hospital charges rendered on October 29, 2024. The insurance carrier denied the charges on May 1, 2025 stating, "Documentation does not support causal relationship to the compensable injury."

   28 TAC §133.307(d)(2)(H) requires that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

   28 TAC §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

   Review of the submitted information finds no copies, as required by Rule §133.307(d)(2)(H), of any PLN-11 or PLN 1 notices issued in accordance with Rule §124.2. The insurance carrier's denial reason is therefore not supported. Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of extent of injury, the respondent has waived the right to raise such issues during dispute resolution. Consequently, the division concludes there are no outstanding issues of compensability, extent, or liability for the injury. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

2. In response to the medical fee dispute resolution request, the insurance carrier stated the following: "An appeal request was received on May 27, 2025, referencing bill #19386586/900000062399. Per Rule 133.250(g), the insurance carrier will issue a final decision on the reconsideration request within 30 days of receipt. At this time, Texas Mutual maintains its position that no payment is due until the reconsideration request has been fully resolved."

   The Division of Workers' Compensation (DWC) finds that, as of the date of this review, the insurance carrier has not submitted a supplemental position statement addressing the reasons for denial related to this dispute. Therefore, the disputed issues will be reviewed in accordance with the applicable rules and guidelines.

3. 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; 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 73590 has status indicator Q1, for STV-packaged codes This code is assigned APC 5521. The OPPS Addendum A rate is $88.05 multiplied by 60% for an unadjusted labor amount of $52.83, in turn multiplied by facility wage index 0.9362 for an adjusted labor amount of $49.46.

  The non-labor portion is 40% of the APC rate, or $35.22.

  The sum of the labor and non-labor portions is $84.68.

  The Medicare facility specific amount is $84.68 multiplied by 200% for a MAR of $169.36.

4. The total recommended reimbursement for the disputed services is $169.36. The insurance carrier paid $0.00. The requestor is seeking additional reimbursement of $166.29. 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 requester has established that additional reimbursement 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 Texas Mutual Insurance Company must remit to Methodist Dallas Medical Center $166.29 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 11, 2025<br>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.