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
Tri-State Insurance Company of Minnesota

MFDR Tracking Number
M4-25-2564-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
June 13, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 16, 2024	N463323025410ML	$0.00	$0.00
July 16, 2024	DRESSING GAUZE 4 X 4	$0.00	$0.00
July 16, 2024	A4622	$0.00	$0.00
July 15, 2024	36415	$0.00	$0.00
July 15, 2024	80048	$0.00	$0.00
July 15, 2024	85027	$0.00	$0.00
July 16, 2024	11012	$250.56	$227.65
July 16, 2024	14040	$1,608.04	$0.00
July 16, 2024	15240	$1,608/04	$0.00
July 16, 2024	ANESTHESIA GEN LEVEL	$0.00	$0.00
July 16, 2024	J0690	$0.00	$0.00
July 16, 2024	J2405	$0.00	$0.00
July 16, 2024	J1100	$0.00	$0.00
July 16, 2024	J2704	$0.00	$0.00
July 16, 2024	J3010	$0.00	$0.00
July 16, 2024	A9270	$0.00	$0.00
July 16, 2024	RECOVERY ROOM 1ST HOUR	$0.00	$0.00
July 16, 2024	96374	$378.00	$0.00

Total	$3,844.64	$227.65

Requester's Position

The requester submitted a document titled "Request for Reconsideration" dated May 9, 2025, "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: $3,844.64

Respondent's Position

"We are attaching a copy of the provider's UB-04 and the carrier's EOBs including the EOB dated September 3, 2024 with recommended payment of $4,783.55. The September 3, 2024 EOB explains the carrier's position concerning the reimbursement amount. The provider is not entitled to any additional reimbursement."

Response submitted by: Flahive, Ogden & Latson

Supplemental response submitted July 28, 2025 by CompIQ Solutions

"This letter is in response to the inquiry regarding the disputed amount of $3466.64 for the service date(s) listed above on the above referenced claimant. I show we have issued payment totaling $5,035.31 so far on this bill. The provider is specifically dispute codes 11012, 14040 and 15240. Procedure 11012 was processed correctly per TX guidelines for CMS OPPS. Procedure 11012 is the J1 status and is the primary procedure on this date. Procedure code 14040 and 15240 are status "T" code; therefore, they are packaged into procedure code 11012 per OPPS guidelines. Therefore, we have not processed payment on these procedures."

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.

Denial Reasons

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

- 881 – This item is an integral part of an emergency room visit or surgical procedure and is therefore included in the reimbursement for the facility/APC rate.
- ANSI97 – 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- RARCM15 – M15 – Separately billed services/tests have been bundled as they are considered component of the same procedure. Separate payment is not allowed.
- 222 – Charge exceeds Fee Schedule allowance.
- ANSIP12 – P12 – Workers compensation jurisdictional fee schedule adjustment.
- B1033 – Processed per Berkley Care Network.
- 776 – Not recognized by OPPS when billed as an OTPT hospital part B.
- 779 – Items, codes and services that are not covered by Medicare.
- ANSI013 – P13 – Payment reduced or denied based on workers compensation jurisdictional regulations or payments policies.
- ANSI18 – 18 – Exact duplicate claim/service.

Issues

1. Is the respondent's position supported?
2. Is the insurance carrier's denial/reduction of payment supported?
3. What is the rule applicable to reimbursement?
4. Is the requester entitled to additional reimbursement?

Findings

1. The respondent states in their position statement, "…I show we have issued payment totaling $5,035.31 so far on this bill." Review of the submitted explanation of benefits dated September 3, 2024 indicates a payment of $4,783.55. Insufficient evidence was found to support the amount of $5,035.31 was paid by the respondent. The payment amount considered in this review is $4,783.55.
2. The requester is seeking additional payment of outpatient hospital charges rendered on July 15 – 16, 2024. The submitted DWC60 indicates the following disputed amounts.
    - 11012 – Paid amount $4,760.64. Amount in dispute $250.56
    - 14040 – Amount in dispute $1,608.04
    - 15240 – Amount in dispute $1608.04
    - 96374 – Amount in dispute $378.00

    The insurance carrier reduced the payment of code 11012 based on workers compensation fee schedule and Berkley Care Network. Review of the information known to the Division does not support the injured worker is enrolled in a certified health network. Therefore, this network

reduction is not supported. The workers' compensation fee schedule calculation is shown below.

Codes 14040, 15240 and 96374 were all denied as packaged. The applicable DWC fee guideline is also shown below.

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 11012 has status indicator "J1", for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5073. The OPPS Addendum A rate is $2,707.35 multiplied by 60% for an unadjusted labor amount of $1,624.61, in turn multiplied by facility wage index 0.8758 for an adjusted labor amount of $1,422.66.

  The non-labor portion is 40% of the APC rate, or $1,082.94.

  The sum of the labor and non-labor portions is $2,505.60.

  The Medicare facility specific amount is $2,505.60 multiplied by 200% for a MAR of $5,011.20.

- Procedure codes have a status indicator "T" and are packaged into primary J1 comprehensive procedure, no separate payment is allowed.
- Procedure code 96374 has a status indicator of "S" and is packaged into primary J1 procedure, no separate payment is allowed.

4. The total recommended reimbursement for the disputed services is $5,011.20. The insurance carrier paid $4,783.55. The amount due is $227.65. This amount is recommended.

Conclusion

Although not all submitted evidence is discussed in detail, it was fully considered in reaching this determination.

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 Tri- State Insurance Company of Minnesota must remit to Doctor's Hospital at Renaissance $227.65 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		August 15, 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.