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

General Information

Requester Name
Methodist Health Systems

Respondent Name
Texas Mutual Insurance Co.

MFDR Tracking Number
M4-25-2673-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
June 23, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 18, 2025 – February 20, 2025	emergency visit	$1,450.68	$0.00

Requester's Position

"Requesting review of unpaid dos."

Amount in Dispute: $1,450.68

Respondent's Position

"The wage index for Methodist Dallas Medical Center is 0.9256, Reimbursement for CPT G0378 was added to the APC/OPPS payment for CPT 99285 for a total of $5,059.07. Our position is that no additional payment is due."

Response submitted by: Texas Mutual Insurance Co.

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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.403 sets out the fee guidelines for outpatient hospital services.

Adjustment Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- W3 & 350 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- DC4 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION.
- 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.
- 767 - PAID PER O/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G)

Issues

1. What rules apply to reimbursement of the services in dispute?
2. Is the requester entitled to additional reimbursement?

Findings

1. This dispute involves reduced payment for emergency room services rendered on February 18, 2025, through February 20, 2025. The insurance carrier issued a payment in the total amount of $5,059.07 and the requester seeks additional payment in the amount of $1,450.68. The insurance carrier reduced the disputed services based on packaging and workers'

compensation fee schedule. The disputed services will be reviewed per applicable fee guidelines.

DWC finds that Rule 28 TAC §134.403 applies to the services in dispute. 28 TAC §134.403(d) requires Texas workers' compensation system participants to apply Medicare payment policies in effect on the date of service for the coding, billing, reporting and reimbursement of professional health care services.

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 the billed amount, if no contracted fee schedule exists that complies with Labor Code §413.011, reimbursement shall be 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*.

2. The requester is seeking additional reimbursement in the amount of $1,450.68 for emergency room services rendered February 18, 2025, through February 20, 2025.

   In accordance with 28 TAC §134.403, 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. The submitted medical bill did not contain implant charges.

   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 to yield the adjusted labor amount. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the adjusted labor amount and the non-labor amount determines the Medicare specific amount. Review of the submitted medical bill and the applicable fee guidelines referenced above are shown below.

   On the disputed date of service, in addition to other procedure codes, the requester charged for procedure code 99285 which is described as Level 5 Type A Emergency Department (ED) Visit.

   A review of the submitted documentation finds that procedure code 99285 meets the criteria for J2 composite observation on the disputed dates of service as the submitted medical bill and medical record indicates more than eight hours of observation. As such, this Emergency

Department visit qualifies for comprehensive payment through APC 8011, comprehensive observation services. All services provided during the disputed dates of service are packaged into the comprehensive payment of the code qualifying for APC 8011, which is procedure code 99285 in this case.

Per OPPS Addendum A, APC 8011 has a payment rate of $2,647.730 for the disputed dates of service. Procedure code 99285, the comprehensive code qualifying for APC 8011 in this claim, has previously received reimbursement in the amount of $5,059.07.

Per a review of the submitted medical bill and the applicable fee guidelines referenced above, reimbursement calculations are outlined below:

Comprehensive APC 8011:

- The OPPS Addendum A, APC rate for the disputed date of service is $2,647.730.
- The unadjusted labor amount is 60% of the APC rate = $1,588.638.
- The unadjusted labor amount of $1,588.638 x the facility wage index 0.9256 = $1,470.443 adjusted labor amount.
- The non-labor portion is 40% of the APC rate = $1,059.092.
- The sum of the adjusted labor amount + the non-labor amount = $2,529.535.
- Therefore, the Medicare facility specific amount = $2,529.535. This amount is multiplied by 200 percent for a MAR of $5,059.07.
- The insurance carrier paid $5,059.07. Additional reimbursement is not recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester 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 requester is entitled to additional reimbursement in the amount of $0.00 for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 6, 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, 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.