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

General Information

Requester Name
University Medical Center

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-25-2728-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
June 30, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 7 -31, 2024 [sic} September 26, 2025 to October 31, 2024	Rev codes 278, 360, 370	$142,267.06	$52,155.03

Requester's Position

"UMC's position is that Paradigm owes $142,267.06 because services were rendered to the patient for a compensable and accepted claim."

Supplemental response August 4, 2025

"I would like to continue with my dispute resolution…"

Amount in Dispute: $142,267.06

Respondent's Position

"The carrier is issuing an additional payment of $73,568.91. We will forward a copy of the carrier's EOB once it is received. It is the carrier's position that with the payment of the additional $90,112.03, the provider would not be entitled to any additional payments."

Supplemental response July 28, 2025

"Carrier has previously responded to this dispute on 07/14/2025. The provider acknowledged that the carrier had already issued payment to it in the amount of $154,362.48. The provider is seeking an additional payment $142,267.06. We are attaching an EOB dated July 9, 2025 that recommended an additional payment of $90,112.03. The provider is not entitled to any additional payments."

Response Submitted by: Flahive, Ogden & Latson

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 133.10 sets out the requirements of requesting separate reimbursement of implants.

3. 28 TAC §134.404 sets out the acute care hospital fee guideline for inpatient services.

Denial Reasons

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

- 18 – Exact duplicate claim/service
- 224 – Duplicate charge
- 252 – An attachment/other documentation is required to adjudicate this claim/service
- 253 – In order to review this charge please submit a copy of the certified invoice
- This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- Corrected bill received: Additional payment of $90,112.03 is being released for the anesthesia and or charges. Please send a copy of the implant invoices for further review.
- 16 – Claim/service lacks information or has submission/billing errors.

Issues

1. Was separate reimbursement of the implants submitted per applicable DWC billing requirement?
2. Is the respondent's reduction in payment supported?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. Is the requester entitled to additional payment?

Findings

1. The requester states in a supplement position statement, "I would like to continue with my dispute resolution as revenue code 278 for implants was not paid…

   DWC Rule 28 TAC 133.10 (f)(2)(QQ) states, "remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested." Review of the submitted medical bill did not contain a request for separate reimbursement of implants. The maximum fee allowable will be determined for inpatient hospital services without a separate request of implants.

2. This dispute regards charges for a 35 day inpatient hospital stay rendered from September 26, 2024 through October 31, 2024. The transfer indicator in box 17 was 62 – discharge/transferred to an inpatient rehabilitation facility including distinct part units of a hospital.

   The insurance carrier supports payments made of $154,362.48 on January 27, 2025 and $90,112.03 on July 9, 2025. Reductions were taken from the billed amount based on the Texas medical fee guideline and Workers' Compensation fee schedule. The disputed services are reviewed per applicable fee guidelines shown below.

   Additionally, the revenue line 278 (implants) was denied for lacking information. As seen above, the requester did not request separate implant reimbursement per the DWC billing requirement. This denial will not be reviewed.

3. The payment of inpatient hospital services is subject to DWC Rule 28 TAC §134.404(f), that requires the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Inpatient Prospective Payment System (IPPS) formulas and factors, as published annually in the Federal Register, with modifications set forth in the rules. Medicare IPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   The division calculates the Medicare facility specific amount using Medicare's *Inpatient PPS PC Pricer* as a tool to efficiently identify and apply IPPS formulas and factors. This software is freely available from www.cms.gov.

   Note: the "VBP adjustment" listed in the *PC Pricer* was removed in calculating the facility amount for this admission. Medicare's Value-Based Purchasing (VBP) program is an initiative to improve quality of care in the Medicare system. However, such programs conflict with Texas Labor Code sections 413.0511 and 413.0512 regarding review and monitoring of health care quality in the Texas workers' compensation system. Rule §134.404(d)(1) requires that specific Labor Code provisions and division rules take precedence over conflicting CMS provisions for administering Medicare. Consequently, VBP adjustments are not considered in determining the facility

reimbursement.

Separate reimbursement for implants was not requested. DWC Rule 28 TAC §134.404(f)(1)(A) requires that the Medicare facility specific amount be multiplied by 143%.

Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 927. The service location is Lubbock, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $213,614.27. Cancellation of the value based purchasing amount of $53.01 resulted in facility specific amount of $213,561.26. This amount multiplied by 143% results in a MAR of $305,392.60.

4. The total recommended payment for the services in dispute is $305,392.60. The insurance carrier paid $244,474.51. The requester stated in their supplement response they are requesting $52,155.03. This amount is 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 University Medical Center has established that additional reimbursement of 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 Zurich American Insurance Co must remit to University Medical Center $52,155.03 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September 25, 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.