



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Methodist Dallas Medical Center

**Respondent Name**

City of Dallas

**MFDR Tracking Number**

M4-25-2922-01

**Carrier's Austin Representative**

Box Number 53

**DWC Date Received**

July 9, 2025

### Summary of Findings

| Dates of Service    | Disputed Services | Amount in Dispute | Amount Due |
|---------------------|-------------------|-------------------|------------|
| January 17-18, 2025 | Emergency visit   | \$6,040.95        | \$0.00     |
| <b>Total</b>        |                   | \$6,040.95        | \$0.00     |

### Requester's Position

"Requesting review of unpaid date of service. Denial states that ICD9 codes were used."

**Amount in Dispute:** \$6,040.95

### Respondent's Position

"Based on the submitted documentation and review of guidelines, a payment is recommended in the amount of \$5,216.97 which includes interest. A copy of the EOB has been included for your reference."

**Response submitted by:** IMO

### 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:

- 97 – The benefit for his service is included in the payment/allowance for another service procedure that has already been adjudicated.
- M15 – Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
- P12 – Workers compensation jurisdictional fee schedule adjustment.

## Issues

1. What is the rule applicable to reimbursement?
2. Is the requester entitled to additional reimbursement?

## Findings

1. The requester is seeking payment of outpatient hospital charges rendered on January 17 – 18, 2025. The insurance carrier submitted a copy of a payment made after MFDR in the amount of \$5,092.74 via check number 435217 on July 28, 2025. Reductions were made per packaging and workers' compensation fee guidelines.

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](http://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;

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 G0378 has status indicator 8011, Comprehensive Observation Services. The OPPS Addendum A rate is \$2,647.73 multiplied by 60% for an unadjusted labor amount of \$1,588.64, in turn multiplied by facility wage index 0.9362 for an adjusted labor amount of \$1,487.28.
  - The non-labor portion is 40% of the APC rate, or \$1,059.09.
  - The sum of the labor and non-labor portions is \$2,546.37.
  - The Medicare facility specific amount is \$2,546.37 multiplied by 200% for a MAR of \$5,092.74.
2. The total recommended reimbursement for the disputed services is \$5,092.74. The insurance carrier paid \$5,092.74. Additional payment is not 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 Methodist Dallas Medical Center 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 \$0.00 additional reimbursement for the disputed services.

## Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
September 25, 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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).