



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Texas Health Huguley Inc

Respondent Name

Arch Indemnity Insurance Company

MFDR Tracking Number

M4-25-2975-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

July 21, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 29, 2025	Inpatient Stay	\$990.81	\$990.81

Requester's Position

"Please reprocess the invoice for an additional allowance as per the IPPS Pricer the calculated amount for the DRG 505 is $\$13,857.78 \times 143\% = \$19,816.63$ ".

Amount in Dispute: \$990.81

Respondent's Position

"The provider filed a DWC 60, seeking Medical Fee Dispute Resolution for a date of service of January 29, 2025. The provider indicated that it billed \$19,816.63 and that the Carrier had paid the provider the amount of \$18,816.63. The provider is seeking an additional payment of \$990.81. We are attaching a copy of the provider's UB-04 and the Carrier's EOB dated February 21, 2025. It is the Carrier's position that the provider was paid pursuant to the Medical Fee Guidelines. The provider is not entitled to any additional reimbursement".

Response Submitted by: Flahive, Ogden & Latson

"Requestor seeks additional reimbursement for the inpatient surgical admission on 1/29/2025. Requestor billed a total of \$42,108.76 for the entire admission. Respondent paid a total of \$18,825.82 for the entire admission. This allowance was calculated per Medicare's IPPS methodology with the applicable state markup. In conclusion, Requestor is not owed any additional allowance for this inpatient admission".

Response Submitted by: Downs & Stanford, P.C.

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. [Texas Insurance Code 1305.006](#) sets out insurance carrier liability for out-of-network health care.
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:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct, therefore, no additional allowance appears to be warranted.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted /legislated fee arrangement.
- 4896 – Payment made per Medicare's IPPS methodology, with applicable state markup.
- CRWK – Careworks/PMCS-or or leased entity contract.
- Network reduction: Careworks/QON/Configurationment.

Issues

1. Is the claim part of a certified healthcare network?
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 is seeking additional reimbursement in the amount of \$990.81 for inpatient hospital facility services, rendered on January 29, 2025. The carrier reduced payment for these services citing reason code CRWK – Careworks/PMCS-or or leased entity contract.

Texas Insurance Code Section 1305.006 states, in relevant part, that health care provided by an out-of-network provider must be pursuant to a referral from the injured employee's treating doctor and approved by the network in accordance with Section 1305.103.

A review of the submitted documentation and information available to the division reveals insufficient evidence that the injured worker is enrolled in a certified healthcare network. Therefore, the carrier's denial is not supported. Consequently, the disputed services are reviewed in accordance with the applicable rules and guidelines.

2. This dispute concerns inpatient hospital facility services provided on January 29, 2025. The insurance carrier reduced payment in accordance with the workers' compensation state fee schedule and Medicare's Inpatient Prospective Payment System (IPPS) methodology, including the applicable state markup. To determine whether the carrier's payment complies with the relevant rules and guidelines, the Division of Workers' Compensation (DWC) will apply Rule 28 TAC §134.404.

The disputed services are therefore reviewed in accordance with the applicable fee guidelines.

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) by 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 505. The service location is Burleson, TX. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is \$13,857.78. The IPPS pricer calculation included a -4.69 amount. With this amount removed (explained above). The corrected Medicare Payment after VBP adj canceled is \$13,862.47. This amount multiplied by 143% results in a MAR of \$19,823.33.

- 2. The total recommended payment for the services in dispute is \$19,823.33. The insurance carrier paid \$18,825.82. The difference between the MAR and the amount paid is \$997.51. The requester is seeking \$990.81. Consistent with DWC guidelines, the recommended additional reimbursement is therefore the lesser of the MAR or the amount requested, as a result, the requester is entitled to an additional payment of \$990.81.

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 established that additional reimbursement of \$990.81 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 Arch Indemnity Insurance Company must remit to Texas Health Huguley Inc \$990.81 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

November 10, 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, 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 electrónico CompConnection@tdi.texas.gov.