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

General Information

Requester Name
Doctors Hospital at Renaissance

Respondent Name
Hartford Insurance Company

MFDR Tracking Number
M4-25-3002-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
July 22, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 21, 2024	N4398220170010UN	$0.00	$0.00
November 21, 2024	DRG SPLINT PLASTER 5"	$0.00	$0.00
November 21, 2024	A4622	$0.00	$0.00
November 21, 2024	DRESSING XEROFORM	$0.00	$0.00
November 21, 2024	C1713	$0.00	$0.00
November 21, 2024	36475	$0.00	$0.00
November 21, 2024	80048	$0.00	$0.00
November 21, 2024	85027	$0.00	$0.00
November 21, 2024	26765	$73.64	$0.00
November 21, 2024	14040	$814.40	$0.00
November 21, 2024	11760	$280.48	$0.00
November 21, 2024	11012	$2,537.22	$0.00
November 21, 2024	ANESTHESIA	$0.00	$0.00
November 21, 2024	J110J30100	$0.00	$0.00
November 21, 2024	J0390	$0.00	$0.00
November 21, 2024	J2704	$0.00	$0.00
November 21, 2024	J2405	$0.00	$0.00
November 21, 2024	A9270	$0.00	$0.00
November 21, 2024	RECOVERY	$0.00	$0.00
November 21, 2024	96374	$0.00	$0.00
	Total	$3,705.74	$0.00

Requester's Position

The requester did not submit a position statement. They did submit a document titled "Reconsideration" dated May 9, 2025 that states, "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: $3,705.74

Respondent's Position

"The original bill for dos 11/21/24 was received on 1/30/25 under control number 222103475 and paid per fee schedule/exceeding the OPPS schedule allowance. There was a partial denial as bundled/included into the total facility payment. Bill processed on 2/11/25."

Response submitted by: The Hartford

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:

- 7 – The cost of the supply is included in the value of another procedure performed on the same date of service.
- 96 – Non-covered charges.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 797 – Service not paid under Medicare OPPS.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 906 – In accordance with clinical based coding edits (NATIONAL CORRECT CODING INITIATIVE/OUTPATIENT CODE EDITOR), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed.

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- TXIP – In order for implants to be considered for reimbursement, please note that provider must request separate reimbursement of implants in writing, including in the request:(1) the manufacturer's invoice for cost of implantables, and (2) certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."
- W3 – Bill is a reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

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 November 21, 2014. The submitted DWC060 listed many lines but the only codes with an amount in dispute are 26765, 14040, 11760 and 11012. The insurance carrier reduced the charges based on fee schedule and packaging.

   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 26765 has status indicator J1, for procedures paid at a comprehensive rate. This code is assigned APC 5113. The OPPS Addendum A rate is $3,084.03 multiplied by 60% for an unadjusted labor amount of $1,850.42, in turn multiplied by facility wage index 0.8758 for an adjusted labor amount of $1,620.60.

  The non-labor portion is 40% of the APC rate, or $1,233.61.

  The sum of the labor and non-labor portions is $2,854.21.

  The Medicare facility specific amount is $2,854.21 multiplied by 200% for a MAR of $5,708.42.

- Procedure code 14040 has status indicator T and is packaged into primary J1 procedure 26765.

- Procedure code 11760 has status indicator T and is packaged into primary J1 procedure 26765.

- Procedure code 11012 has status indicator J1. Medicare payment policy for comprehensive packaging only allows payment of the highest ranked J1 procedure. Review of the applicable addendum J1 at www.cms.gov found the ranking of 2,514 for code 11012. Code 26765 has a ranking of 2,012. Code 26765 is the highest ranked and receives payment.

2. The total recommended reimbursement for the disputed services is $5,708.42. The insurance carrier paid $5,708.42. 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 the requester has not established that additional reimbursement of $3,705.74 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		August 21, 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.