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

General Information

Requester Name
Texas Health Huguley

Respondent Name
Safety National Casualty Corp

MFDR Tracking Number
M4-25-3022-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 23, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 2, 2025	96372	$175.97	$0.00
May 2, 2025	99284	$540.78	$0.00
May 2, 2025	93005	$41.24	$0.00
	Total	$757.99	$0.00

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a document dated July 15, 225 titled "Reconsideration" that states, "Per EOB received, billed charges were not paid correctly per TX work comp guidelines. According to TX Workers Compensation Fee Sched the expected reimbursement for DOS 5/2/2025 is $1,404.19."

Amount in Dispute: $757.99

Respondent's Position

"Our initial response to the above refenced medical fee dispute resolution is as follows: We have escalated the bills in question for manual review to determine if additional monies are owed."

Supplemental response August 21, 2025

"…We have completed our review of the State Dispute. As previously indicated, the bill was fee

schedule priced to $1,056.66. We have identified some lines of services were allowed in error, which should have been denied as packaged, while other lines of service were not priced appropriately per the fee schedule. CPT codes 9637[sic], 36415, 80053, 83880, 83690, 84484 and 85025 were allowed in error. While the 3 codes in dispute, 96372, 99284, and 93005 were short paid per the fee schedule."

Response submitted by: Gallagher Bassett

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:

- 197 – Precertification/authorization/notification/pre-treatment absent.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
- TX360 – Allowance for this procedure was made at the usual and customary amount for this geographical area.
- TX370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- TX616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- TX975 – This line item was reviewed using the FAIR HEALTH CHARGE BENCHMARK DATABASE module based on the provider geographic area.
- XXJ49 – The allowance for this line has been summed with other allowances on the bill and re-distributed evenly.
- XXU00 – There was no UR procedure/treatment request received.

- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

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 May 2, 2025. The insurance carrier reduced the charges based on packaging, and workers' compensation fee schedule. The requester indicates on the submitted DWC060 that only codes 96372, 99284 and 93005 are in dispute. In their response, Gallagher Bassett stated, "We have identified some line of services were allowed in error, which should have been denied as packaged while other lines of service were not priced appropriately per the fee schedule." The charges listed on the medical bill will be reviewed per applicable fee guideline.

   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 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 96372 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is packaged into code 99284. No separate reimbursement.
- Procedure code 36415 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 80053 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 83880 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 83690 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 84484 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 85025 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 71250 has status indicator Q3, for conditionally packaged codes paid as a composite if OPPS criteria are met. As packaging criteria were not met, this line is separate. This code is assigned APC 5522. The OPPS Addendum A rate is $106.34 multiplied by 60% for an unadjusted labor amount of $63.80, in turn multiplied by facility wage index 0.9256 for an adjusted labor amount of $59.05.

  The non-labor portion is 40% of the APC rate, or $42.54.

  The sum of the labor and non-labor portions is $101.59.

  The Medicare facility specific amount is $101.59 multiplied by 200% for a MAR of $203.18.
- Procedure code 99284 has status indicator J2 when billed with 8 or more hours of observation billed. As observation hours were not on this medical bill, this code is assigned APC 5024 with a status indicator of V.

  The OPPS Addendum A rate is $425.82 is multiplied by 60% for an unadjusted labor amount of $255.49, in turn multiplied by facility wage index 0.9256 for an adjusted labor amount of $236.48.

  The non-labor portion is 40% of the APC rate, or $170.33.

  The sum of the labor and non-labor portions is $406.81.

  The Medicare facility specific amount is $406.81 is multiplied by 200% for a MAR of $813.62.
- Procedure code J1885 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.

- Procedure code 93005 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is packaged into code 99284. No separate reimbursement.

2. The total recommended reimbursement for the disputed services is $1,016.80. The insurance carrier paid $1,056.68. 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 Texas Health Huguley has not established that additional reimbursement of $757.99 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

		August 28, 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.