



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Doctors Hospital at Renaissance

Respondent Name

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-25-3193-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

August 6, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 16 – 17, 2024	Inpatient Stay	\$6,212.79	\$6,212.79

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a copy of a document titled "Reconsideration" that states, "After reviewing the account we have concluded that reimbursement received was inaccurate. DRG 493, allowed amount is \$16,820.57, multiplied at 143% reimbursement should be \$24,053.41. Payment was only \$17,840.62, thus, according to these calculations; there is a pending payment in the amount of \$6,212.79."

Amount in Dispute: \$6,212.79

Respondent's Position

"Please see the EOB included in with Requestor's DWC-60. The Carrier has paid a total of \$17,840.62, for the entire admission. This amount was inclusive of the entire surgical procedure, the APC rate plus the markup. In conclusion, Requestor is not owed any additional reimbursement for the surgical procedure."

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 §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:

- 2008 – Additional payment made on appeal/reconsideration
- 6514 – Timely filing reconsidered
- W3 – Bill is a reconsideration or appeal
- 247 – A payment or denial has already been recommended for this service.
- 18 – Exact duplicate claim/service.

Issues

1. Is the respondent's position supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requester entitled to additional payment?

Findings

1. The respondent states in their position statement, "...This amount was inclusive of the entire surgical procedure, the APC rate plus the markup." However, the requester in this dispute billed for inpatient hospital facility services rendered from October 16, 2024 to October 17 17, 2024. The insurance carrier reimbursed under the outpatient hospital fee service schedule. The applicable fee guideline is shown below.
2. 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 862 The service location is Edinburg, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is \$17,317.62. The IPPS Pricer indicates for this provider a VBP adjustment of -\$54.52 was taken from the claim estimate. As shown above, the DWC Rules take precedence, the negative adjustment of \$54.52 is added back into the claim estimate, making the Medicare facility specific amount \$17,372.14. This amount multiplied by 143% results in a MAR of \$24,842.16.

3. The total recommended payment for the services in dispute is \$24,842.16. The insurance carrier paid \$17,840.61. The requester is seeking \$6,212.79. 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 Doctors Hospital at Renaissance has established that additional reimbursement of \$6,212.79 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 Indemnity Insurance Co of North America must remit to Doctor's Hospital at Renaissance \$6,212.79 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

August 29, 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.