TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Dallas County Hospital District

Respondent Name
City of Dallas

MFDR Tracking Number
M4-25-3196-01

Carrier's Austin Representative
Box Number 53

DWC Date Received
August 1, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 4-5, 2024	Inpatient Stay	$61,375.67	$61,375.67

Requester's Position

"Parkland Hospital ("Hospital) has been underpaid by Tristar or their representative ("Payor") regarding the above reference hospital bill. The bill is underpaid in accordance with the Texas Administrative Code as outlined in Title 28, Part 2 Texas Department of Insurance, Division of Workers' Compensation, Chapter 134, Subchapter E, Rule §134.403.

Amount in Dispute: $61,375.67

Respondent's Position

"Following a thorough review of the claim history and the accompanying documentation. The date of service has previously been paid in full per the submitted billed charges. …The TPA received zero response to our request for bill correction."

Response Submitted by: Injury Management Organization, Inc.

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:

- B13 – Previously paid. Payment for this claim/service may have been provided in previous payment.
- 16 – Claim/service lacks information or has submission/billing error(s).
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- N713 – Incomplete/Invalid report.
- W3 – TDI Level 1 Appeal means a request for reconsideration under 133.250 of the title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title.
- Notes: The submitted billed charges are less than the DRG reimbursement. Original submission paid in full. Please submit corrected claim.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requester entitled to additional payment?

Findings

1. This dispute regards inpatient hospital facility services rendered on September 4 – 5, 2024. The insurance carrier indicates the original submission amount was paid in full.

   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 to 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 935. The service location is Dallas, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $60,560.76 (cancelling the VBP adjustment -$25.02) = $60,585.78. This amount multiplied by 143% results in a MAR of $86,637.67.

2. The total recommended payment for the services in dispute is $86,637.67. The insurance carrier paid $25,226.22. The requester is seeking payment of $61,375.67. 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 the Dallas County Hospital has established that additional reimbursement of $61,375.67 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 City of Dallas must remit to Dallas County Hospital $61,375.67 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

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.