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

General Information

Requester Name
Tarrant Co Hospital District

Respondent Name
American Casualty Co of Reading

MFDR Tracking Number
M4-25-3280-01

Carrier's Austin Representative
Box Number 57

DWC Date Received
August 14, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 19 – 21, 2024	Inpatient Stay	$5,732.94	$5,732.94

Requester's Position

"The bill is for a 2-day inpatient stay that should pay per TDI rule 134.404. The carrier originally paid 73811.00. We then submitted an appeal due to the bill being underpaid and the carrier has denied additional reimbursement. The DRG was 906 and the allowed amount is $79543.94. It only paid $7381.00."

Amount in Dispute: $5,732.94

Respondent's Position

"On receipt of this DWC60 Medical Fee Dispute Resolution, the Carrier contacted its bill review vendor and confirmed the Healthcare provider under-billed for services, failed to timely submit a corrected claim, and is not entitled to any additional reimbursement."

Response Submitted by: Law offices of Brian J. Judis

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:

- Note: Allowance is max at charges. Corrected billing is required for additional payment if applicable.
- 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
- 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.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

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 included the following Rule reference, "Per Rule 134.203(h)(2) the Carrier shall reimburse a healthcare provider at the least of: the MAR amount, the billed charge or the fair and reasonable reimbursement amount consistent with the standards of § 134.1 of this title." The rule relevant to the reimbursement of impatient hospital services is found in 28 TAC §134.404 (e)(1)(2) that states,

   Except as provided in subsection (h) of this section, **regardless of billed amount**, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

   (2) 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.

Insufficient evidence was found to support a contract exists between the two parties. The fee calculation 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 906 The service location is Fort Worth, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $55,727.83 (VBP adjustment of -$102.70 canceled.). This amount multiplied by 143% results in a MAR of $79,690.80.

3. The total recommended payment for the services in dispute is $79,690.80. The insurance carrier paid $73,811.00. The requester is seeking an additional payment of $5,732.94. 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 Tarrant County Hospital District has established that additional reimbursement of $5,732.94 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 American Casualty Co of Reading must remit to Tarrant County Hospital District $5,732.94 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.