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
Doctors Hospital at Renaissance

Respondent Name
Arch Insurance Co

MFDR Tracking Number
M4-25-3321-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 19, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 4, 2025	N416729043293ML	$0.00	$0.00
February 4, 2025	Drsg Splint Plaster 5" Gr	$0.00	$0.00
February 4, 2025	A4622	$0.00	$0.00
February 4, 2025	Dressing Gauze 4" x 4" ST	$0.00	$0.00
February 4, 2025	C1713	$0.00	$0.00
February 4, 2025	36415	$0.00	$0.00
February 4, 2025	80048	$0.00	$0.00
February 4, 2025	85027	$0.00	$0.00
February 4, 2025	11760	$560.96	$0.00
February 4, 2025	14040	$1,628.80	$0.00
February 4, 2025	26765	$0.00	$0.00
February 4, 2025	11012	$2,537.92	$0.00
February 4, 2025	Anesthesia Gen Level-1 F1	$0.00	$0.00
February 4, 2025	J1885	$0.00	$0.00
February 4, 2025	J1171	$0.00	$0.00
February 4, 2025	J2405	$0.00	$0.00
February 4, 2025	J2250	$0.00	$0.00
February 4, 2025	J0690	$0.00	$0.00

February 4, 2025	J2704	$0.00	$0.00
February 4, 2025	J1100	$0.00	$0.00
February 4, 2025	A9270	$0.00	$0.00
February 4, 2025	Recovery Room 1st Hour	$0.00	$0.00
February 4, 2025	96374	$0.00	$0.00
	Total	$5,110.56	$0.00

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 'Request for Reconsideration' dated July 2, 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: $5,110.56

Respondent's Position

"It is the carrier's position that the provider was reimbursed in accordance with the Medical Fee Guidelines. The provider is not entitled to any additional monies."

Response submitted by: Flahive, Ogden & Latson

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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
3. 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:

- 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.
- 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 (9000-99999) has been disallowed.
- 96 – Non-covered charge(s).
- 97 – Payment adjusted because 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.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Bill is a 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 on February 4, 2025. The insurance carrier reduced and denied the charges based on workers' compensation fee schedule and packaging. The applicable DWC Rules and fee guidelines are discussed below.

   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)(1)(A)(B) 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; (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 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 Claims Processing Manual Chapter 4, Section 10.3 at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.p, explains, 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. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5113. The OPPS Addendum A rate is $3,244.61 multiplied by 60% for an unadjusted labor amount of $1,946.77, in turn multiplied by facility wage index 0.8983 for an adjusted labor amount of $1,748.78.

  The non-labor portion is 40% of the APC rate, or $1,297.84.

  The sum of the labor and non-labor portions is $3,046.62.

  The Medicare facility specific amount is $3,046.62 multiplied by 200% for a MAR of $6,093.24.
- Procedure code 11760 has a status indicator of T. Reimbursement for this is included with payment for the primary procedure. Separate payment is not recommended.
- Procedure code 14040 has a status indicator of T. Reimbursement for this is included with payment for the primary procedure. Separate payment is not recommended.
- Procedure code 11012 has a status indicator of J1. The applicable Medicare payment policy allows for payment on only the highest ranked J1 procedure. Code 11012 has a ranking of 2,484. Code 26765 has a ranking of 2,123 which is the highest ranked J1 code and the only code that can be paid..

2. The total recommended reimbursement for the disputed services is $6,093.24. The insurance carrier paid $6,094.74. 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 Doctor's Hospital at Renaissance has not established that additional reimbursement of $5,110.56 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

Signature	Medical Fee Dispute Resolution Officer	September 8, 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 electronico CompConnection@tdi.texas.gov.