



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Memorial Hermann
Surgical Hospital

Respondent Name

United Airlines Inc.

MFDR Tracking Number

M4-25-3327-01

Carrier's Austin Representative

Box Number 17

DWC Date Received

August 19, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 30, 2025	24345	\$3,929.86	\$3,929.85

Requester's Position

"Per EOB received, CPT code 24345 was not paid correctly per TX work comp guidelines."

Amount in Dispute: \$3,929.86

Respondent's Position

"...the information provided by Requestor on the DWC-60 is inaccurate. Provider originally billed \$15,068.00 for CPT code 24345RT. The total billed amount for the outpatient admission was \$22,690.72. Please see the medical bill received. Requestor allotted \$9, 208.87 for CPT code 24345 and a total reimbursement of \$10,380.75 for the entire surgical outpatient admission. This amount is inclusive of the entire surgical procedure. Therefore, no additional reimbursement is owed."

Response submitted by: Downs ♦ Stanford, P.C.

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:

- 45 – charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P5 – Based on Payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
- 360 – Allowance for this procedure was made at the usual and customary amount for this geographical area.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- PDC – This bill was reviewed in accordance with your Coventry contract.
- PK6 – Subject to CHCWC/United Airlines TX HCN. A certified TX HCN.

Issues

1. Are the insurance carrier's reductions supported?
2. What is the rule applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking payment of outpatient hospital charges rendered January 30, 2025. The insurance carrier reduced the payment amount noting a Coventry contract. Information available to the Division found insufficient evidence to support the injured employee was enrolled in a certified health network. Any reduction based on a contract/network is not

supported. The services in dispute will be reviewed per applicable DWC fee guideline for outpatient hospital services.

2. 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*.

- (1) 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 reimbursement is calculated below.

3. 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 24345 has status indicator J1, for procedures paid at a comprehensive rate. All the services covered on the bill are packaged with the primary "J1" procedure. This code is assigned to APC 5114. The OPPS Addendum A rate is \$7,143.73 multiplied by 60% for an unadjusted labor amount of \$4,286.24, in turn multiplied by facility wage index 1.0027 for an adjusted labor amount of \$4,297.81.

The non-labor portion is 40% of the APC rate, or \$2,857.49.

The sum of the labor and non-labor portions is \$7,155.30.

The Medicare facility specific amount is \$7,155.30 multiplied by 200% for a MAR of \$14,310.60.

The total recommended reimbursement for the disputed services is \$14,310.60. The insurance carrier paid \$10,380.75. The amount due is \$3,929.85. This amount is 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 Memorial Hermann Surgical Hospital Sugarland has established that additional reimbursement \$3,929.85 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 United Airlines Inc must remit to Memorial Hermann Surgical Hospital Sugarland \$3,929.85 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

September 25, 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.