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

General Information

Requester Name
Metroplex Adventist Hospital

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-25-3390-01

Carrier's Austin Representative
Box Number 45

DWC Date Received
August 25, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 4, 2025	96372	$418.51	$0.00
March 4, 2025	72100	$208.44	$0.00
March 4, 2025	99284	$834.68	$0.00
March 4, 2025	J1885	$5,88	$0.00
	Total	$1,467.51	$0.00

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a document titled, "Reconsideration" dated August 12, 2025 that states, "Per EOB received, bill denied stating diagnosis codes do not correlate to an actual injury. Please note that patient received treatment for (redacted), and prior DOS 11/17/2024 was paid using same billed diagnosis code (redacted).

Supplemental response submitted September 30, 2025

"Carrier paid $838.44 and balance of $629.07 still owed. Please continue with dispute."

Amount in Dispute: $1,467.51

Respondent's Position

"Upon notification of this dispute, the Office researched Metroplex Adventist Hospital's medical billing and determined that payment would be allowed. The Office, out of good faith, has requested an immediate re-audit of the bill allow payment, including applicable interest."

Response submitted by: SORM

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:

- 16 – Claim/service lacks information which is needed for adjudication
- 251 – The attachment content received did not contain the content required to process this claim or service.
- The indicated/pointed to diagnosis codes do not correlate to an actual injury. Please identify and utilize a diagnosis code that correlates to the actual injury being treated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 97 – The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated.
- W3 – Reporting purposes only.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly

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 March 4, 2025. The insurance carrier denied the charges originally based on the diagnosis. This denial was not maintained and a payment issued. However, the requester asked to continue with the dispute.

   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*.

   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 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 96372 has status indicator Q1, for STV-packaged codes; reimbursement is included with payment for any other service assigned status S, T or V. This code is packaged into code 99284 with a V status indicator.
   - Procedure code 72100 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is packaged into code 99284 with a V status indicator.
   - Procedure code 99284 has a status indicator of J2 when billed in conjunction with 8 or more hours of observation. As no observation services were submitted, this code is assigned APC 5024 with a status indicator of V. The Addenda A reimbursement rate is $425.82 x 60% = $255.49 x provider specific wage index of 0.9668 = $247.01 the adjusted labor amount

$425.82 x 40% = $170.33 the non-labor amount

The sum of the adjusted labor amount ($247.01) and the non-labor amount ($170.33) = $417.34

Provider specific Medicare payment amount of $417.34 x 200% = $834.68

- Procedure code J1885 has status indicator K1. This code is assigned APC 764. The OPPS Addendum A rate is $0.75 multiplied by 60% for an unadjusted labor amount of $0.45, in turn multiplied by facility wage index 0.9668 for an adjusted labor amount of $0.44.

  The non-labor portion is 40% of the APC rate, or $0.30.

  The sum of the labor and non-labor portions is $0.74.

- The Medicare facility specific amount is $0.74 x 4 units = $2.96 multiplied by 200% for a MAR of $5.92.

2. The total recommended reimbursement for the disputed services is $840.60. The insurance carrier paid $838.44. 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 requester has not established that additional reimbursement 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	October 20, 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.