



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Texas Health Huguley, Inc

Respondent Name

Texas Mutual Insurance

MFDR Tracking Number

M4-26-0226-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

September 22, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 15, 2025	DRG 464	\$2,688.85	\$10.21

Requester's Position

The requester did not submit a position statement with this request for MFDR.

Amount in Dispute: \$2,688.85

Respondent's Position

"Texas Health Huguley Inc. provided inpatient services billed under DRG 464 and is requesting an additional payment of \$2,688.85. Texas Mutual issued a payment of \$29,159.29 based on patient status code 06 discharged to home with home health care in accordance with Medicare's Transfer Policy under the Inpatient Prospective Payment System (IPPS), as outlined in Rule 134.404(d)(3)."

Response Submitted by: Texas Mutual

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:

- CAC-21 – Workers compensation state fee schedule adjustment.
- 687 – This service was priced according to the Medicare transfer policy under the inpatient prospective payment system.
- CAC-18 – Exact duplicate claim/service.
- 224 – Duplicate charge.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 891 – No additional payment after reconsideration.

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 in May of 2025. The insurance carrier reduced the payment based on Medicare transfer policy.

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 464. The service location is Burleson, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is \$20,391.00 with the VBP reduction of \$-7.16 added back in, the Medicare facility specific amount after cancellation of the VBP amount adjustment is \$20,398.25. This amount multiplied by 143% results in an MAR of \$29,169.50.

2. The total recommended payment for the services in dispute is \$29,169.50. The insurance carrier paid \$29,169.29. The requester is entitled to an additional payment of \$10.21. 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 requester has established that additional reimbursement of \$10.21 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 Texas Mutual Insurance Co must remit to Texas Health Huguley, \$10.21 plus applicable accrued interest within 30 days of receiving this order in accordance with [28 TAC §134.130](#).

Authorized Signature

_____	_____	October 14, 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 electrónico CompConnection@tdi.texas.gov.