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
Methodist Health Systems

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-26-0249-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
September 24, 2026

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
Per Submitted Medical Claim May 15, 2025	Emergency visit	$6,204.73	$0.00

Requester's Position

"Requesting review of unpaid date of service."

Supplemental response submitted November 17, 2025

"We did receive a payment of $5133.09 but still show a balance of $1071.64."

Amount in Dispute: $6,204.73

Respondent's Position

"To resolve this fee reimbursement dispute, Texas Mutual has elected to reprocess the disputed services in accordance with the appropriate Medical Fee Guideline as defined per Texas Administrative Code Rule 134 – Guidelines for Medical Services, Charges and Payments."

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

- 28 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.
- 28 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:

- 40 – Charges do not meet qualifications for emergent/urgent care.
- 898 – Documentation and file review does not support an emergency in accordance with Rule 133.2.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- DC3 – Additional reimbursement allowed after reconsideration.
- DC4 – No additional reimbursement allowed after reconsideration.
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 630 – This service is packaged with other services performed on the same date and reimbursement is based on a single composite APC rate.
- 767 – Paid per O/P FG at 200%; Implants not applicable or separate reimbursement (with cert) not requested per Rule 134.403(G).
- 920 – Reimbursement is being allowed based upon a dispute.

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 May 15, 2025. The insurance carrier denied the charges originally as definition of emergency not met but after receiving the request for MFDR, a payment was made but the requester wished to continue with MFDR.

   The disputed charges will be reviewed per the applicable fee guidelines.

   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 G0378 has status indicator J2, for outpatient visits (subject to comprehensive packaging when 8 or more hours observation billed). This code is assigned APC 8011. The OPPS Addendum A rate is $2,647.73 multiplied by 60% for an unadjusted

labor amount of $1,588.64, in turn multiplied by facility wage index 0.9256 for an adjusted labor amount of $1,470.45.

The non-labor portion is 40% of the APC rate, or $1,059.09.

The sum of the labor and non-labor portions is $2,529.54.

The Medicare facility specific amount is $2,529.54 multiplied by 200% for a MAR of $5,059.08.

2. The total recommended reimbursement for the disputed services is $5,059.08. The insurance carrier paid $5,059.07. 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	December 10, 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.