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

General Information

Requester Name

Methodist Health Systems

Respondent Name

City of Richardson

MFDR Tracking Number

M4-26-0509-01

Insurance Carrier's Austin Representative

BOX 44 White Espey PLLC

DWC Date Received

October 22, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
March 17, 2025 - March 18, 2025	EMERGENCY VISIT	$6,821.95	$5,092.74
	Total	$6,821.95	$5,092.74

Requester's Position

Requesting confirmation of non-compensability.

Amount In Dispute: $6,821.95

Respondent's Position

The Austin carrier representative for City of Richardson is White Espey PLLC. The representative was notified of this medical fee dispute on October 24, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code Section 413.031 and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section 133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC 124.2 sets out insurance carrier notification requirements.
3. 28 TAC Section 134.203 sets out the fee guidelines for professional medical services.

Adjustment Reasons

- T167 – This (these) diagnosis (es) is (are) not covered.

Issues

1. What is DWC considering in this medical fee dispute?
2. Did the insurance carrier support the submitted diagnosis are non-covered?
3. What rule is applicable to reimbursement?
4. Is the requester entitled to reimbursement?

Findings

1. The requester is seeking payment of outpatient emergency room hospital charges rendered on March 17 – 18, 2025. The insurance denied the claim based on non-covered diagnosis. The amount in dispute is $6,821.95.
2. 28 TAC Section 133.307(d)(2)(H) requires that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

   28 TAC Section 124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

Review of the submitted information finds no copies, as required by Rule Section 133.307(d)(2)(H), of any PLN-11 or PLN 1 notices issued in accordance with Rule 28 TAC Section 124.2.

The insurance carrier's denial reason is therefore not supported. Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of extent of injury, the respondent has waived the right to raise such issues during dispute resolution.

Consequently, the division concludes there are no outstanding issues of compensability, extent, or liability for the injury. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

3. 28 TAC Section 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).

   28 TAC Section 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.

   28 TAC Section 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 99285 has an APC of 8011 for comprehensive observation when emergency room services are billed with greater than eight hours of observation. All services rendered are packaged into comprehensive APC and a single payment amount is made.

  The Addenda A allowable is $2,647.73 multiplied by 60% = $1,588.64 multiplied by the wage index is 0.9362 equals and adjusted labor amount of $1,487.28

  The APC allowable $2,647.73 multiplied by 40% equals the non-labor amount $1,059.09

  The addition of the labor amount and non-labor amount equals a facility specific allowed amount of $2,546.37.

  The facility specific payment amount is $2,546.37 multiplied by 200% = $5,092.74.

4. The total recommended reimbursement for the disputed services is $5,092.74. This amount is recommended

Conclusion

The outcome of this medical fee dispute is based on the evidence requester and the respondent presented at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that City of Richrdson must remit to Methodist Health System $5,092.74 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

		January 30, 2026
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 Section 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 800-252-7031, option three 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section 141.1(d).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.