



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Doctors Hospital at Renaissance

**Respondent Name**

Zurich American Ins Co of Illinois

**MFDR Tracking Number**

M4-26-0517-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

October 22, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 3, 2024	N417478082301ML	\$0.00	\$0.00
December 4, 2024	M400781922209ML	\$0.00	\$0.00
December 4, 2024	IV NS ADD-A-VIAL BAG 100M	\$0.00	\$0.00
December 3, 2024	PRE-OP INJ IV PUSH INITIAL	\$0.00	\$0.00
December 3, 2024	A6222	\$0.00	\$0.00
December 3, 2024	DRESSING GAUZE 4'X4' ST	\$0.00	\$0.00
December 3, 2024	87073	\$0.00	\$0.00
December 3, 2024	36415	\$0.00	\$0.00
December 3, 2024	80053	\$0.00	\$0.00
December 4, 2024	84100	\$0.00	\$0.00
December 4, 2024	80053	\$0.00	\$0.00
December 4, 2024	83735	\$0.00	\$0.00
December 3, 2024	85610	\$0.00	\$0.00
December 3, 2024	85730	\$0.00	\$0.00
December 3, 2024	85025	\$0.00	\$0.00
December 4, 2024	85025	\$0.00	\$0.00
December 3, 2024	87040	\$0.00	\$0.00
December 3, 2024	86850	\$0.00	\$0.00
December 3, 2024	86900	\$0.00	\$0.00

December 3, 2024	86901	\$0.00	\$0.00
December 3, 2024	73130	\$55.98	\$0.00
December 3, 2024	26952	\$1195.44	\$0.00
December 3, 2024	15240	\$50,351.49	\$0.00
December 3, 2024	ANESTHESIA GEN LEVEL-1	\$0.00	\$0.00
December 3, 2024	99285	\$626.05	\$0.00
December 3, 2024	J2704	\$0.00	\$0.00
December 3, 2024	J3010	\$0.00	\$0.00
December 3, 2024	J2250	\$0.00	\$0.00
December 3, 2024	J3370	\$0.00	\$0.00
December 3, 2024	J0295	\$0.00	\$0.00
December 3, 2024	J7120	\$0.00	\$0.00
December 3, 2024	J2405	\$0.00	\$0.00
December 3, 2024	90471	\$99.48	\$0.00
December 3, 2024	J2270	\$0.00	\$0.00
December 3, 2024	J1596	\$0.00	\$0.00
December 3, 2024	J1100	\$0.00	\$0.00
December 4, 2024	J7120	\$0.00	\$0.00
December 4, 2024	J0295	\$0.00	\$0.00
December 3, 2024	A9270	\$0.00	\$0.00
December 4, 2024	A9270	\$0.00	\$0.00
December 3, 2024	RECOVERY ROOM 1 <sup>ST</sup> HOUR	\$0.00	\$0.00
December 3, 2024	G0378	\$0.00	\$0.00
December 3, 2024	90471	\$0.00	\$0.00
<b>Total</b>		<b>\$52,328.44</b>	<b>\$0.00</b>

### Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration that states, "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

**Amount in Dispute:** \$52,328.44

### Respondent's Position

"The provider has been paid all of the monies that the provider is entitled to under the Medical Fee Guidelines."

**Response submitted by:** Flahive, Ogden & Latson

### 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.
- 95 – Plan procedures not followed.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 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.

### Issues

1. Is the insurance carrier's reduction 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 in December 2024. The insurance carrier reduced the disputed charges based on "Coventry" contract and workers' compensation fee schedule.

Review of the submitted information available to the Division at the time of this review found insufficient evidence to support the injured worker was enrolled in a certified health network. The calculation of the Maximum Allowed Reimbursement (MAR) is found below.

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](http://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)(1)(A) 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 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 for services listed with a dispute amount on the DWC060.

- Procedure code 73130 has a status indicator of Q1 and is packaged into primary J1 procedure 26952.
- Procedure code 26952 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5113. The OPPS Addendum A rate is \$3,084.03 multiplied by 60% for an unadjusted labor amount of \$1,850.42, in turn multiplied by facility wage index 0.8758 for an adjusted labor amount of \$1,620.60.  
The non-labor portion is 40% of the APC rate, or \$1,233.61.  
The sum of the labor and non-labor portions is \$2,854.21.  
The Medicare facility specific amount is \$2,854.21 multiplied by 200% for a MAR of \$5,708.42.
- Procedure code 15240 has a status indicator of T and is packaged into primary J1 procedure 26952.

- Procedure code 99285 has a status indicator of J2 and is packaged into primary J1 procedure 26952.
  - Procedure code 90471 has a status indicator of Q1 and is packaged into primary J1 procedure 26952.
3. The total recommended reimbursement for the disputed services is \$5,708.42. The insurance carrier paid \$13,031.30. 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**

		November 13, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).