



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Doctors Hospital at Renaissance

Respondent Name

La Joya ISD

MFDR Tracking Number

M4-26-0619-01

Carrier's Austin Representative

Box Number 17

DWC Date Received

November 3, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 9, 2025	N46068739579ML	\$0.00	\$0.00
January 9, 2025	IV NS ADD-A-VIAL BAG 100M	\$0.00	\$0.00
January 9, 2025	PRE-OP INS IV USH INITIA	\$0.00	\$0.00
January 9, 2025	OR DERMABOND HIGH VISCOSI	\$0.00	\$0.00
January 8, 2025	36415	\$0.00	\$0.00
January 8, 2025	80053	\$0.00	\$0.00
January 9, 2025	82962	\$0.00	\$0.00
January 8, 2025	85027	\$0.00	\$0.00
January 8, 2025	85610	\$0.00	\$0.00
January 8, 2025	85730	\$0.00	\$0.00
January 8, 2025	81001	\$0.00	\$0.00
January 9, 2025	29880	\$996.11	\$8.07
January 9, 2025	ANESTHESIA GEN LEVEL-1	\$0.00	\$0.00
January 9, 2025	94640	\$370.16	\$0.00
January 9, 2025	J2405	\$0.00	\$0.00

January 9, 2025	J0690	\$0.00	\$0.00
January 9, 2025	J1885	\$1.25	\$1.13
January 9, 2025	J1596	\$8.34	\$7.38
January 9, 2025	J2270	\$0.00	\$0.00
January 9, 2025	J2003	\$0.00	\$0.00
January 9, 2025	J2704	\$0.00	\$0.00
January 9, 2025	J3301	\$0.00	\$0.00
January 9, 2025	J3010	\$0.00	\$0.00
January 9, 2025	J2250	\$0.00	\$0.00
January 9, 2025	J0171	\$0.00	\$0.00
January 9, 2025	J2710	\$0.00	\$0.00
January 9, 2025	J7030	\$0.00	\$0.00
January 9, 2025	A9270	\$0.00	\$0.00
January 9, 2025	RECOVERY ROOM 1 ST HOUR	\$0.00	\$0.00
Total		\$1,109.85	\$16.58

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: \$1,109.85

Respondent's Position

"Carrier asserts it has paid properly and according to fee guidelines, and has reviewed this bill twice, once initially and once on reconsideration. No additional recommendation of payment."

Response submitted by: Claims Administrative Services, Inc.

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:

- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 975 – This line item was reviewed using the fair health charge benchmark database module based on the provider geographic area.
- J49 – The allowance for this line has been summed with other allowances on the bill and re-distributed evenly.
- 371 – This hospital outpatient allowance was calculated according to the OPPS payment for this service.
- 617 – This item or service is not covered or payable under the Medicare Outpatient fee schedule.
- 360 – Allowance for this procedure was made at the usual and customary amount for this geographical area.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- P5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. What is the rule applicable to reimbursement?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking additional reimbursement for outpatient hospital services rendered in January of 2025. The insurance carrier reduced the allowable based on the workers' compensation fee schedule and Medicare fee schedule. 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 29880 has status indicator J1. This code is assigned APC 5113. The OPPS Addendum A rate is \$3,244.61 multiplied by 60% for an unadjusted labor amount of \$1,946.77, in turn multiplied by facility wage index 0.8983 for an adjusted labor amount of \$1,748.78.

The non-labor portion is 40% of the APC rate, or \$1,297.84.

The sum of the labor and non-labor portions is \$3,046.62.

The Medicare facility specific amount is \$3,046.62 multiplied by 200% for a MAR of \$6,093.24.

- Procedure code 94640 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for comprehensive J1 procedure.
- Procedure code J1885 has status indicator K1, for nonpass-through drugs and biologicals separately paid by APC. This code is assigned APC 761. The OPPS Addendum A rate is \$0.68 multiplied by 60% for an unadjusted labor amount of \$0.41, in turn multiplied by facility wage index 0.8983 for an adjusted labor amount of \$0.37.

The non-labor portion is 40% of the APC rate, or \$0.27.

The sum of the labor and non-labor portions is \$0.64.

The Medicare facility specific amount is \$0.64 multiplied by 200% for a MAR of \$1.28.

- Procedure code J1596 has status indicator K1, for nonpass-through drugs and biologicals separately paid by APC. This code is assigned APC 792. The OPPS Addendum A rate is \$0.51 multiplied by 60% for an unadjusted labor amount of \$0.31, in turn multiplied by facility wage index 0.8983 for an adjusted labor amount of \$0.28.

The non-labor portion is 40% of the APC rate, or \$0.20.

The sum of the labor and non-labor portions is \$0.48.

The Medicare facility specific amount is \$0.48 multiplied by 200% for a MAR of \$0.96 multiplied by 8 units = \$7.68.

2. The total recommended reimbursement for the disputed services is \$6,101.20. The insurance carrier paid \$6,084.62. The amount due is \$16.58. This amount is 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 established that additional reimbursement 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 La Joya ISD must remit to Doctor’s Hospital at Renaissance \$16.58 plus applicable accrued interest within 30 days of receiving this order in accordance with [28 TAC §134.130](#).

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

December 4, 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 electrónico CompConnection@tdi.texas.gov.