



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Doctors Hospital at Renaissance

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-26-0652-01

Carrier's Austin Representative

Box Number 45

DWC Date Received

November 3, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 14, 2025	N400143925010ML	\$0.00	\$0.00
May 14, 2025	AN AIRWAY 100MM	\$0.00	\$0.00
May 14, 2025	DRESSING ABD PAD 8X10	\$0.00	\$0.00
May 14, 2025	C1713	\$0.00	\$0.00
May 14, 2025	C1763	\$0.00	\$0.00
May 14, 2025	36415	\$0.00	\$0.00
May 14, 2025	80051	\$0.00	\$0.00
May 14, 2025	85027	\$0.00	\$0.00
May 14, 2025	29833	\$3,046.62	\$0.00
May 14, 2025	27428	\$0.00	\$0.00
May 14, 2025	ANESTHESIA GEN LEVEL	\$0.00	\$0.00
May 14, 2025	J1596	\$0.82	\$0.00
May 14, 2025	J1885	\$0.00	\$0.00
May 14, 2025	J3010	\$0.00	\$0.00
May 14, 2025	J2795	\$0.00	\$0.00
May 14, 2025	J1171	\$0.00	\$0.00
May 14, 2025	J2405	\$0.00	\$0.00
May 14, 2025	J2250	\$0.00	\$0.00

May 14, 2025	J0665	\$0.00	\$0.00
May 14, 2025	J0690	\$0.00	\$0.00
May 14, 2025	J3370	\$0.00	\$0.00
May 14, 2025	J2704	\$0.00	\$0.00
May 14, 2025	J2710	\$0.00	\$0.00
May 14, 2025	J1100	\$0.00	\$0.00
May 14, 2025	A9270	\$0.00	\$0.00
May 14, 2025	RECOVERY ROOM 1 ST HOUR	\$0.00	\$0.00
May 14, 2025	96374	\$396.56	\$0.00
Total		\$3,442.28	\$0.00

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: \$3,442.28

Respondent's Position

"Medicare's payment policies, as written, show that CPT code 96374 is an SI packaged item. CPT codes 27428 and 29883 have a packaged APC allowance as they have a J1 indicator that is reimbursed through a comprehensive ambulatory payment classification. When multiple J1 status codes are on the same bill, only one with the highest payment rate if [sic] reimbursed at 100% and the others are packaged. ...reimbursement is paying the highest reimbursing procedure code 27428."

Response submitted by: SORM

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:

- P12 – Workers’ compensation jurisdictional fee schedule adjustment.
- 97 – The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated.

Issues

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

Findings

1. The requester seeks additional payment for services rendered on May 14, 2025 in an outpatient hospital. The insurance carrier reduced the payment amount based on the workers’ compensation fee schedule and packaging.

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)(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*.

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 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 eight units = \$3.84 multiplied by 200% for a MAR of \$7.66. The insurance carrier paid \$0.63. The requester is seeking \$0.82.

- Procedure code 29833 has a status indicator of J1. However, the applicable Medicare payment only allows payment on the highest ranked J1 procedure. Review of the applicable J1 addenda at www.cms.gov, found Code 29833 has a ranking of 1,858. Code 27428 has a ranking of 187 and is the only J1 procedure eligible for payment.
- Procedure code 27428 has status indicator J1 and is not in dispute.
- Procedure code 96374 has a status indicator of S and is packaged into comprehensive J1 procedure.

2. The amount requested by the health care provider is less than \$2.00. No payment 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 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

November 26, 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.