



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Memorial Health Systems

**Respondent Name**

Nationwide Insurance Company

**MFDR Tracking Number**

M4-26-0799-01

**Carrier's Austin Representative**

Box Number 06

**DWC Date Received**

November 18, 2025

### Summary of Findings

| Dates of Service   | Disputed Services | Amount in Dispute | Amount Due |
|--------------------|-------------------|-------------------|------------|
| September 15, 2025 | 73630             | \$394.05          | \$0.00     |

### Requestor's Position

The requester did not submit a position statement with this request for MFDR.

**Amount in Dispute:** \$394.05

### Respondent's Position

"According to the carrier's bill review company Enlyte, it is the carrier's position that the bill was correctly audited as indicated on the initial EOR."

**Response Submitted by:** Stone, Loughlin & Swanson LLP

### 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

1. [28 Texas Administrative Code \(TAC\) §133.305](#) sets out the procedures for resolving medical disputes.
2. [28 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §134.403](#) sets out the rules and fee guidelines for outpatient hospital services.

## Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 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.

## Issues

1. Were the services in dispute rendered outside the State of Texas?
2. Is insurance carriers denial based on packaging supported?

## Findings

1. The requestor is a health care provider that rendered disputed services in the state of Florida to an injured employee with an existing Texas Workers’ Compensation claim.

The health care provider was dissatisfied with the insurance carrier’s final action.

The health care provider has requested medical fee dispute resolution under 28 TAC §133.307.

Because the requestor has sought the administrative remedy outlined in 28 TAC §133.307, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers’ Compensation Act and applicable rules.

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) 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*.

Review of the submitted medical bill and the applicable fee guidelines referenced above are shown below.

- Procedure code 73630 has a Status Indicator of Q1. The definition of Q1 is – Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “S”, “T”, or “V” per OPPS Addenda at [www.cms.gov](http://www.cms.gov).

The other line item on the submitted medical bill was 99283 which has a status indicator of “V”.

Based on this review DWC finds the insurance carrier’s denial based on packaging is supported. No additional reimbursement 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 requestor is entitled to \$0.00 additional reimbursement for the disputed services.

### **Authorized Signature**

\_\_\_\_\_  
Signature

Medical Fee Dispute Resolution Officer

December 30, 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](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).