



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Methodist Health System

**Respondent Name**

Keller ISD

**MFDR Tracking Number**

M4-25-0802-01

**Insurance Carrier's Austin Representative**

BOX 43 Sedgwick York Risk Services Group

**DWC Date Received**

November 18, 2025

### Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
April 23, 2025 – April 30, 2025	Outpatient procedure	\$17,516.01	\$0.00
<b>Total</b>		\$17,516.01	\$0.00

### Requester's Position

"This initial bill was underpaid. The reconsideration was denied for timely filing."

**Amount In Dispute:** \$17,516.01

### Respondent's Position

The Austin carrier representative for Keller ISD is Sedgwick York Services Grp. The representative was notified of this medical fee dispute on November 21, 2025

Per 28 Texas Administrative Code §133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then 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 Section [134.403](#) sets out the guidelines for outpatient hospital services.

### Adjustment Reasons

- The allowed amount is zero because this is packaged with a Status Indicator J1 on another line.
- Surgical. The allowed amount was calculated using the Whole APC ((Labor Portion: 0.62 \* APC Payment Rate: 12,866.82) \* Wage Index: 0.93) + ((1 – Labor Portion: 0.62) \* APC Payment Rate: 12,866.82)) \* Units:1 \*Implants included Uplift of 2.00 Status Indicator: J1

### Issues

1. What is DWC considering in this medical fee dispute?
2. What rule applies to the calculation of the fee guideline for outpatient hospital procedures?
3. Has DWC determined whether additional reimbursement is due?

### Findings

1. The requester is seeking additional reimbursement in the amount of \$17,516.01 for outpatient hospital procedures rendered from April 23 – 30, 2025.
2. 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](http://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.

Review of the submitted information finds that the medical bill contained code G0378 – “Hospital observation service, per hour.”

The Medicare payment policy specific to comprehensive observation services is found at [www.cms.gov](http://www.cms.gov), **MLN Matters Number MM9486** and states in pertinent part, Comprehensive Observation Services C-APC (APC 8011), ... effective January 1, 2016, CMS has created new Status Indicator (SI) J2 to designate specific combinations of services that, when performed in combination with each other and reported on a hospital Medicare Part B outpatient claim, would allow for all other OPPS payable services and items reported on the claim (excluding all preventive services and certain Medicare Part B inpatient services) to be deemed adjunctive services representing components of a comprehensive service and resulting in a **single prospective payment through C-APC 8011 for the comprehensive service** based on the costs of all reported services on the claim.

Review of the submitted medical bill finds a total of 164 units for code G0378 was billed. Therefore, this bill meets the Medicare payment policy criteria for APC 8011 which is discussed below.

- Procedure code G0378 has status indicator J2, for outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed). This code is assigned APC 8011. The OPPS Addendum A rate is \$2,647.73 multiplied by 60% for

an unadjusted labor amount of \$1,588.64, in turn multiplied by facility wage index 0.9256 for an adjusted labor amount of \$1,470.45.

The non-labor portion is 40% of the APC rate, or \$1,059.09.

The sum of the labor and non-labor portions is \$2,529.54.

The Medicare facility specific amount is \$2,529.54 multiplied by 200% for a MAR of \$5,059.08.

3. The total recommended reimbursement for the disputed services is \$5,059.08. The insurance carrier paid \$7,028.99. Additional payment is not recommended.

### Conclusion

The outcome of this medical fee dispute is based on the evidence the 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 not established that additional reimbursement is due.

### **Order**

Under Texas Labor Code Sections [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

April 24, 2026  
\_\_\_\_\_  
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](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 800-252-7031, option three 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 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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).