



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Methodist Health Systems

Respondent Name

Zurich American Insurance Company

MFDR Tracking Number

M4-26-0803-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

November 18, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 28 – 31, 2025	Inpatient Stay	\$15,785.14	\$0.00

Requester's Position

"Attached a copy of the CMS Pricer. Grand total \$13,421.22 x Texas Inpatient Uplift 143% = \$19,192.34 - \$8414.50 paid leave a balance of \$10,777.84."

Amount in Dispute: \$15,785.14

Respondent's Position

"We believe that the parties both agree that the reimbursement rate is 143% of the IPPS value. Our calculations are \$5884.25 x 143% which totals \$8414.50. The provider is appealing payment based on the billing address. However, the bill was already processed correctly based upon the practice address, the service performed hospital address. The provider is not entitled to any monies."

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

1. [28 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.404](#) sets out the acute care hospital fee guideline for inpatient services.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Which provider number is associated with the facility where the services were provided?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requester entitled to additional payment?

Findings

1. This dispute regards inpatient hospital facility services rendered in August of 2025 in Methodist Midlothian Medical in Midlothian, Texas. The requester submitted a copy of the CMS IPPS Pricer that indicates a provider number of 450051. However, review of CMS wage index at www.cms.gov, found a provider number of 670300 for Methodist Midlothian Medical Center. This provider number will be utilized in the calculation of the applicable DRG payment.
2. The payment of inpatient hospital services is subject to DWC Rule 28 TAC §134.404(f), that requires the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Inpatient Prospective Payment System (IPPS) formulas and factors, as published annually in the Federal Register, with modifications set forth in the rules. Medicare IPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at <http://www.cms.gov>.

The division calculates the Medicare facility specific amount using Medicare's *Inpatient PPS PC Pricer* as a tool to efficiently identify and apply IPPS formulas and factors. This software is freely available from www.cms.gov.

Note: the "VBP adjustment" listed in the *PC Pricer* was removed in calculating the facility amount for this admission. Medicare's Value-Based Purchasing (VBP) program is an initiative to improve quality of care in the Medicare system. However, such programs conflict with Texas Labor Code sections 413.0511 and 413.0512 regarding review and monitoring of health care quality in the Texas workers' compensation system. Rule §134.404(d)(1) requires that specific Labor Code provisions and division rules take precedence over conflicting CMS provisions for administering Medicare. Consequently, VBP adjustments are not considered in determining the facility reimbursement.

Separate reimbursement for implants was not requested. DWC Rule 28 TAC §134.404(f)(1)(A) requires that the Medicare facility specific amount be multiplied by 143%.

Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 558. The service location is Midlothian, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is 5,884.26. The IPPS Pricer amount includes a VBP of \$30.00 which once removed results in a corrected Medicare facility specific amount of \$5,854.26. This amount multiplied by 143% results in a MAR of \$8,371.59.

3. The total recommended payment for the services in dispute is \$8,371.59. The insurance carrier paid \$8,414.50. No additional payment is due.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester 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 of 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

December 18, 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.