TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Doctors Hospital at Renaissance

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-26-0871-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 25, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 15, 2025	29125	$242.06	$0.00
May 15, 2025	15240	$3,435.22	$0.00
May 15, 2025	94640	$381.96	$0.00
May 15, 2025	93005	$111.56	$0.00
May 15, 2025	96374	$395.66	$0.00
May 15, 2025	All other lines	$0.00	$0.00
	Total	$4,566.46	$0.00

Requester's Position

"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: $4,566.46

Respondent's Position

"Our medical bill review has reviewed the dispute and found that nothing further is due."

Response submitted by: Broadspire

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.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- P13 – Payment reduce or denied based on Workers' compensation jurisdictional regulations or payment policies.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- D00 – Based on further review, no additional allowance is warranted.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 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.
- 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup.
- 617 – This item or service is not covered or payable under the Medicare Outpatient fee schedule.

Issues

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

Findings

1. The requester is seeking payment of outpatient hospital charges rendered on May 15, 2025. The insurance carrier reduced the submitted charges based on the workers' compensation fee schedule and packaging. The DWC fee guideline is calculated as follows.

   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 26952 has a Status Indicator of J1 a comprehensive payment. All Part B services covered on a claim are packaged with the primary J1 service. This code is not in dispute.
   - Procedure code 29125 has a status indicator of Q1 and is packaged into primary comprehensive J1 procedure.
   - Procedure code 15240 has a status indicator of T and is packaged into primary comprehensive J1 procedure.
   - Procedure code 94640 has a status indicator of Q1 and is packaged into primary comprehensive J1 procedure.

- Procedure code 93005 has a status indicator of Q1 and is packaged into primary comprehensive J1 procedure.
- Procedure code 96374 has a status indicator of S and is packaged into primary comprehensive J1 procedure.

2. Based on this review, the Division finds that, based on applicable fee guidelines for outpatient hospital services, no additional 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

		December 29, 2025
Signature	Medical Fee Dispute Resolution Officer	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 electronico CompConnection@tdi.texas.gov.