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

Pampa Healthcare Services

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-26-1712-01

Insurance Carrier's Austin Representative

BOX 54 Texas Mutual Insurance Co

DWC Date Received

February 18, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
September 25, 2025	111-110	$13200.00	$0.00
September 25, 2025	111-250	$5866.44	$0.00
September 25, 2025	111-258	$178.16	$0.00
September 25, 2025	111-259	$9.00	$0.00
September 25, 2025	111-259	$11.36	$0.00
September 25, 2025	111-259	$51.84	$0.00
September 25, 2025	111-259	$20.16	$0.00
September 25, 2025	111-259	$15.04	$0.00
September 25, 2025	111-259	$77.44	$0.00
September 25, 2025	111-259	$39.00	$0.00

September 25, 2025	111-259	$3.00	$0.00
September 25, 2025	111-259	$96.72	$0.00
September 25, 2025	111-259	$6.00	$0.00
September 25, 2025	111-259	$3.00	$0.00
September 25, 2025	111-259	$15.00	$0.00
September 25, 2025	111-270	$425.90	$0.00
September 25, 2025	111-272	$15522.13	$0.00
September 25, 2025	111-278	$24560.79	$0.00
September 25, 2025	111-300	$209.00	$0.00
September 25, 2025	111-301	$1309.01	$0.00
September 25, 2025	111-305	$1037.61	$0.00
September 25, 2025	111-320	$2793.03	$0.00
September 25, 2025	111-352	$2965.59	$0.00
September 25, 2025	111-360	$26250.00	$0.00
September 25, 2025	111-370	$4697.04	$0.00
September 25, 2025	111-421	$478.50	$0.00
September 25, 2025	111-424	$424.63	$0.00
September 25, 2025	111-430	$169.32	$0.00
September 25, 2025	111-434	$1446.24	$0.00
September 25, 2025	111-450	$6321.09	$0.00
September 25, 2025	111-710	$1320.00	$0.00
September 25, 2025	111-730	$437.25	$0.00
	Total	$110,005.69	$0.00

Requester's Position

"Please be advised the Medicare ID is (redacted) for this provider, Also Medicare ID number is not required for processing workers compensation. Please review and process for payment per the TX fee schedule."

Amount In Dispute: $110,005.69

Respondent's Position

"On 11/11/2025 Texas Mutual received the attached medical bill without a valid Medicare CCN/PTAN/Oscar number that is required to determine the DRG payment allowed. This was communicated on the explanation of benefits that was returned to the provider. Additionally, Texas Mutual has not received an appeal with the required missing information in accordance with TAC 28 133.307(c)(2)(J). ...Our position is that no payment is due."

Response Submitted By: Texas Mutual

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. Labor Code Section 413.011 sets out the requirements for fair and reasonable reimbursement.
3. 28 TAC Section 134.1 defines medical reimbursement policies.

Adjustment Reasons

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation.
- 523 – A Medicare number is required to calculated the CMS Inpatient Reimbursement.

Issues

1. What is DWC considering in this medical fee dispute?

2. What rule(s) apply to Critical Access Hospital Reimbursement?
3. Did the requester submit sufficient documentation to support the fair and reasonable reimbursement rate of $110,005.69?
4. Is the requester entitled to reimbursement for the services in dispute?

Findings

1. The requester is seeking reimbursement for inpatient Critical Access Hospital Services rendered from September 25 – 30, 2025 in the amount of $110,005.69. The insurance carrier denied the services as provider number not provided.

2. Review of the information on the medical bill (box 56) specifies that the NPI number of the rendering provider is 1700509577. According to CMS NPI Registry at http://www.npiregistry.cms.hhs.gov, this NPI is associated with General Acute Care Hospital – Critical Access.

   The Medicare Claims Processing Manual, Chapter 4 – Part B Hospital, Section 120.1 – Bill Types Subject to OPPS, The following bill types are subject to OPPS:

   "All outpatient hospital Part B bills (bill types 12X, 13X with condition code 41 14X and 13X without condition code 41) ***with the exception of bills*** *from hospitals in Maryland, Indian Health Service,* ***CAH****s,"*

   Based on the above, the applicable fee guideline is **not** in 28 TAC Section 134.403 related to services provided in an outpatient acute care hospital.

   28 TAC Section 134.1 sets out the guidelines for reimbursement for medical services. Specifically, 28 TAC Section 134.1(e) states that healthcare services not provided through a workers' compensation healthcare network must be reimbursed based on:

   - Division fee guidelines.
   - A negotiated contract; or
   - A fair and reasonable reimbursement amount under subsection (f), when neither of the above apply.

   As shown above, Critical Access services are not covered under the Division's fee guidelines and neither party submitted documentation for a negotiated contract. Hence, the service in dispute falls to a fair and reasonable reimbursement amount as set out in 28 TAC 134.1(f).

   28 TAC Section 134.1(f) defines fair and reasonable reimbursement as a rate that:

   - Complies with Labor Code Section 413.011 criteria.
   - Ensures similar procedures in similar circumstances receive similar reimbursement; **and**

- It is based on nationally recognized published studies, Division medical dispute decisions, and/or valuations for comparable services.

Labor Code Section 413.011 mandates that fee guidelines be:

- Fair and reasonable,
- Promote quality care and cost control,
- Encourage timely return to work, and
- Avoid excessive payments compared to similar care for individuals with comparable standards of living.

3. 28 TAC Section 133.307 requires the requester to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with Section 134.1 of this title (relating to Medical Reimbursement) . . . when the dispute involves health care for which the DWC has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

   28 TAC Section 133.307 requires a position statement of the disputed issue(s) that should include:

   (i) the requester's reasoning for why the disputed fees should be paid or refunded,

   (ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and

   (iii) how the submitted documentation supports the requester's position for each disputed fee issue.

   The information submitted for this review did not provide sufficient documentation or a position statement that satisfies the requirements outlined above.

   28 TAC Section 134.1(f) and Texas Labor Code Section 413.011, require that payment be based on a "fair and reasonable" standard.

   Because no Division fee guideline or negotiated contract applies, the disputed services must be evaluated under the statutory and regulatory criteria for fair and reasonable reimbursement.

   After a review of the submitted documentation and applicable standards, DWC finds that the requested reimbursement rate of $110,005.69 is not supported for the following

reasons.

The requester did not provide documentation demonstrating that the billed charges for the disputed services reflect a fair and reasonable reimbursement rate as required under 28 TAC Section 134.1 and Labor Code Section 413.011.

A health care provider's "usual and customary" charges, standing alone, do not constitute evidence of a fair and reasonable reimbursement rate. Such charges do not establish what insurers customarily pay for the same or similar services in comparable circumstances.

Permitting reimbursement based solely on the provider's billed charges would effectively place payment determination within the provider's unilateral control. This outcome would be inconsistent with:

- The statutory objective of effective medical cost control, and
- The requirement that reimbursement does not exceed the amount paid for similar treatment of an injured individual of an equivalent standard of living, as contemplated by Labor Code Section 413.011.

Accordingly, usual and customary charges cannot be favorably considered absent additional objective data or documentation substantiating that the requested amount is fair and reasonable.

The requester did not submit documentation to demonstrate how the requested reimbursement:

- Ensures the quality of medical care, and
- Achieves effective medical cost control as expressly required by Texas Labor Code Section 413.011.

The statute requires that reimbursement methodologies balance adequate provider compensation with system-wide cost containment. No evidence was provided to establish that the requested $110,005.69 satisfies this statutory framework.

The requester did not provide:

- Nationally recognized published studies,
- Independent fee analyses,
- Benchmarking data, or
- Documentation of values assigned to services involving similar work and resource commitments to substantiate the requested reimbursement amount.

Without objective comparative data, the Division cannot determine that the requested rate aligns with fair market values for services requiring comparable time, skill, intensity, and

resources.

The requester did not establish that payment of the requested amount satisfies the requirements set forth in 28 TAC Section 134.1, which governs reimbursement when no fee guideline applies. The documentation submitted does not demonstrate that the requested rate is reasonable within the context of the Texas workers' compensation system.

4. At the MFDR level, the requester bears the burden of proof to establish entitlement to reimbursement by a preponderance of the evidence.

   DWC finds that the requester failed to submit sufficient documentation to support that the requested $110,005.69 constitutes a fair and reasonable reimbursement under applicable statutes and rules.

   Because the evidentiary burden has not been met, payment cannot be recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence 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 reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to $0.00 reimbursement for the disputed services.

Authorized Signatures

Signature	Medical Fee Dispute Resolution Officer	June 24, 2026 Date
Signature	Director of Medical Fee Dispute Resolution	June 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. 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.

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 electronico CompConnection@tdi.texas.gov.