



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Tarrant County Hospital District

**Respondent Name**

State Office of Risk Management

**MFDR Tracking Number**

M4-26-1900-01

**Insurance Carrier's Austin Representative**

BOX 45 State Of Texas

**DWC Date Received**

March 5, 2026

### Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
July 23, 2025 – July 30, 2025	Inpatient Hospital	\$30,550.00	\$30,550.00
<b>Total</b>		\$30,550.00	\$30,550.00

### Requester's Position

"Inpatient Medical bills should pay the DRG rate provided by Medicare at 143% with implant included. Original bill processed paying \$69,652.49. I submitted a reconsideration for the underpayment of \$31,944.02. The carrier made an additional payment of \$1,394.02. This is still underpaid by \$30,550.00. Please review this documentation for additional fees due."

**Amount In Dispute:** \$30,550.00

### Respondent's Position

"This will acknowledge receipt of the request for medical fee dispute resolution by the State Office of Risk Management (Office) on the above-referenced **Workers' Compensation network claim**."

Upon notification of this dispute, the Office researched billing received from Tarrant County Hospital District. It was determined that payment was reimbursed at the network rate per the providers contract, show by the 45 Reason Code on both explanation of benefits."

**Response Submitted By:** State Office Of Risk Management

## **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 [134.404](#) sets out the acute care hospital guidelines for inpatient services.

### Adjustment Reasons

The insurance carrier reduced payment for the disputed services with the following reasons:

1. 45 – Charges exceed your contracted/legislated fee arrangement
2. 97 – The benefit for this service is included in the pymnt/allowance for another service procedure that has already been adjudicated
3. B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
4. W3 – Reporting purposes only
5. 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
6. P12 – Workers' compensation jurisdictional fee schedule adjustment. Note: if adjustment is at the claim level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 other claim relate information REF) If adjustment is at the line level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 service payment information REF) if the regulations apply. To be used for Workers' Compensation only

### Issues

1. What is DWC considering in this medical fee dispute?
2. Does the division have jurisdiction to review this medical fee dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. Is the requester entitled to additional payment?

### Findings

1. Requester is seeking reimbursement in the amount of \$30,550.00 for Inpatient Hospital services rendered on July 23, 2025 through July 30, 2025. The insurance carrier made a

payment in the amount of \$71,046.51 and denied the remaining charges with the denial reasons indicated above.

2. DWC MFDR has jurisdiction under 28 TAC Section 133.305 and 133.307, which limits its review to non-network claims and certain out-of-network services.

In this case, the DWC determined the carrier failed to support network enrollment because:

- No documentation was provided showing the injured employee was enrolled in a certified Health Care Network (HCN).
- No evidence showed the provider was contractually required to follow network procedures.

Additionally, DWC records contained no notice from the carrier reporting that the employee was enrolled in a certified HCN.

- Texas Labor Code Section 413.031(a)(1) – providers may request review when payment is denied or reduced.
- Texas Labor Code Section 413.031(c) – DWC adjudicates payment disputes for medically necessary services.

Therefore, the DWC concluded it does have jurisdiction to resolve the dispute.

3. A review of the explanation of benefits and medical bills finds that the requester billed for inpatient facility charges provided from July 23, 2025 – July 30, 2025, in the amount of \$102,475.00. The insurance carrier issued a payment in the amount of \$71,046.51, and the requester seeks an additional payment of \$30,550.00.

To determine if the requester is entitled to additional reimbursement, the division refers to 28 TAC Section 134.404(f). This regulation outlines the criteria for reimbursement of inpatient medical services. The division will review the submitted evidence to determine if additional reimbursement is warranted.

This dispute pertains to inpatient hospital facility services with payment subject to 28 TAC Section 134.404(f), requiring 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](http://www.cms.gov).

Separate reimbursement for implants was not requested. 28 TAC Section 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 956. The service location is Fort Worth, TX. Based on the DRG code, service location, and bill-specific information, the Medicare facility specific amount is \$71,046.51. This amount multiplied by 143% results in a MAR of \$101,596.51.

4. The total allowable reimbursement for services in dispute is \$101,596.51. The amount previously paid by the insurance carrier is \$71,046.51. The requester is therefore entitled to an additional reimbursement amount of \$30,550.00.

### 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 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 additional reimbursement for the disputed services. It is ordered that State Office Of Risk Management must remit to Tarrant County Hospital District \$30,550.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section [134.130](#).

### **Authorized Signature**

  
\_\_\_\_\_  
Signature

  
\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

April 3, 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).