



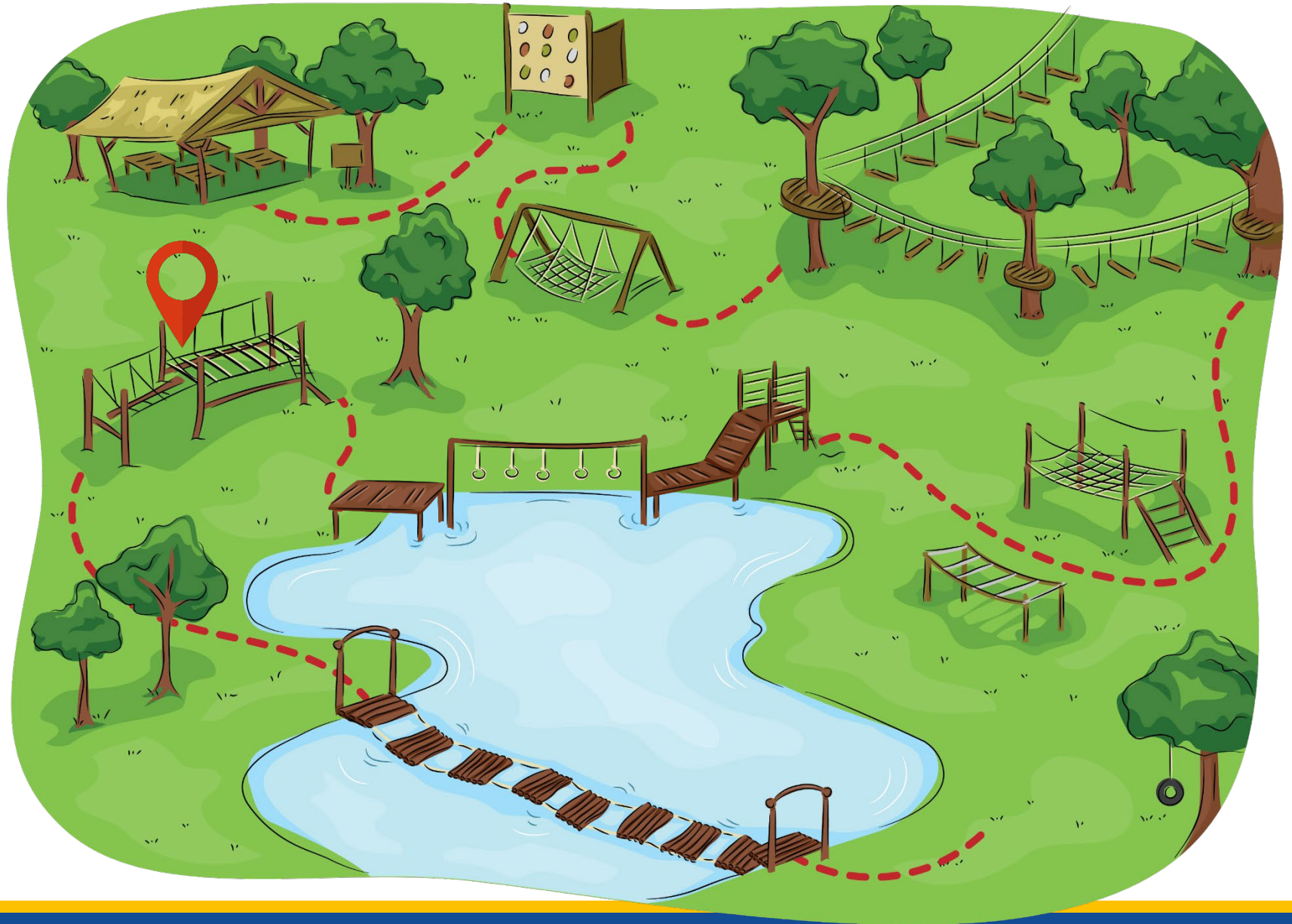
HEALTH CARE PROVIDER

>>> *Professional Reimbursement* <<<



Division of Workers'
Compensation

Day 3





HEALTH CARE PROVIDER

>>> *Professional Reimbursement* <<<

Learning Objectives

- Learn the how to calculate professional reimbursement.
- Know some exceptions to Medicare payment policies.
- Understand billing for workers' compensation specific services like case management services.



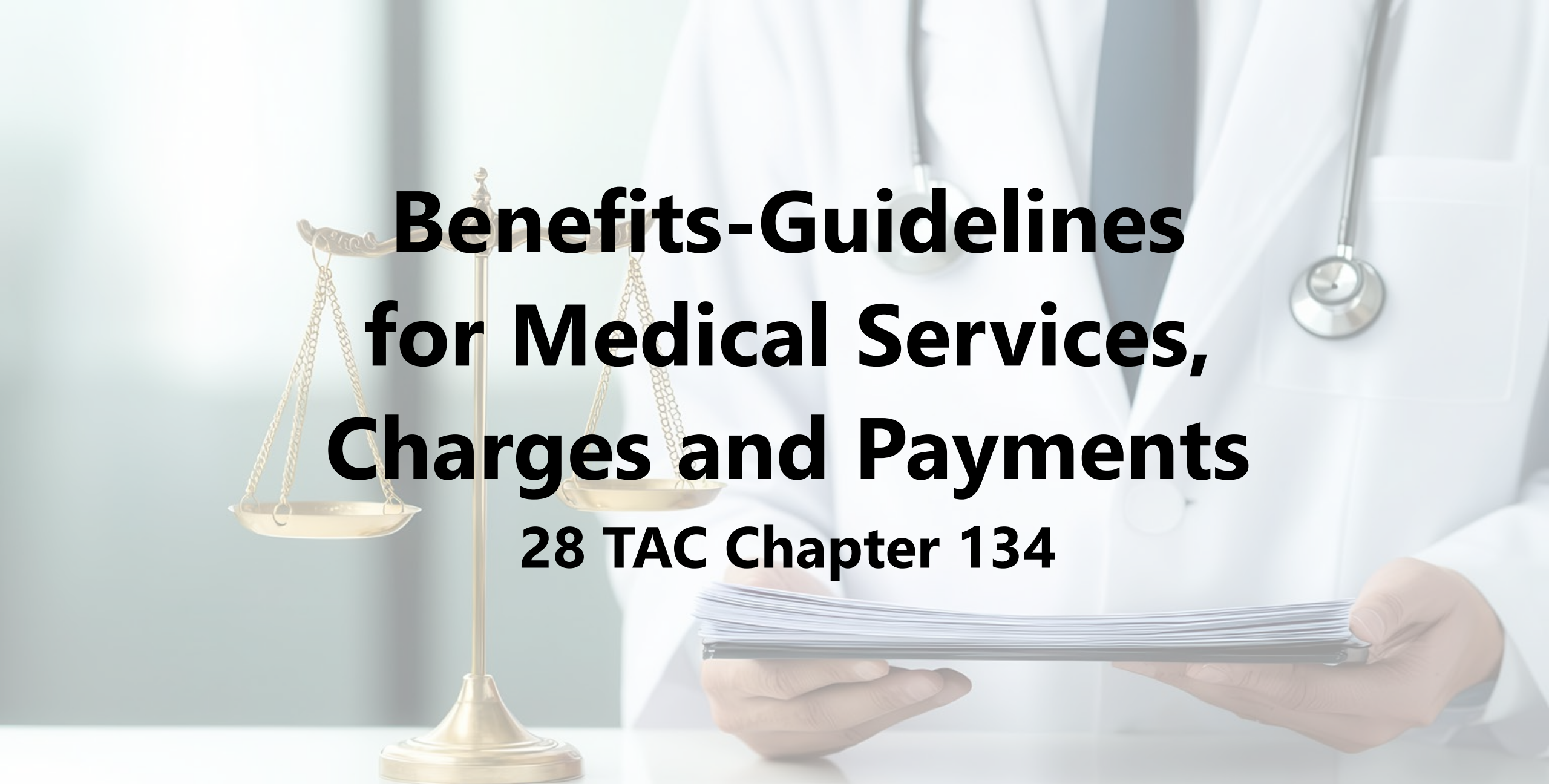
Disclaimer

This presentation is updated as of **June 16, 2026**, and is for educational purposes only and provides general information. It is not a substitute for a full review of statutes and rules.

System participants are responsible for knowing and complying with the applicable sections of the [Texas Insurance Code](#) (Insurance Code), [Texas Labor Code](#) (Labor Code), and [Texas Administrative Code](#) (TAC).

Any opinions expressed by the speakers are personal and do not constitute or reflect any statement of policy by the Texas Department of Insurance, Division of Workers' Compensation (DWC).



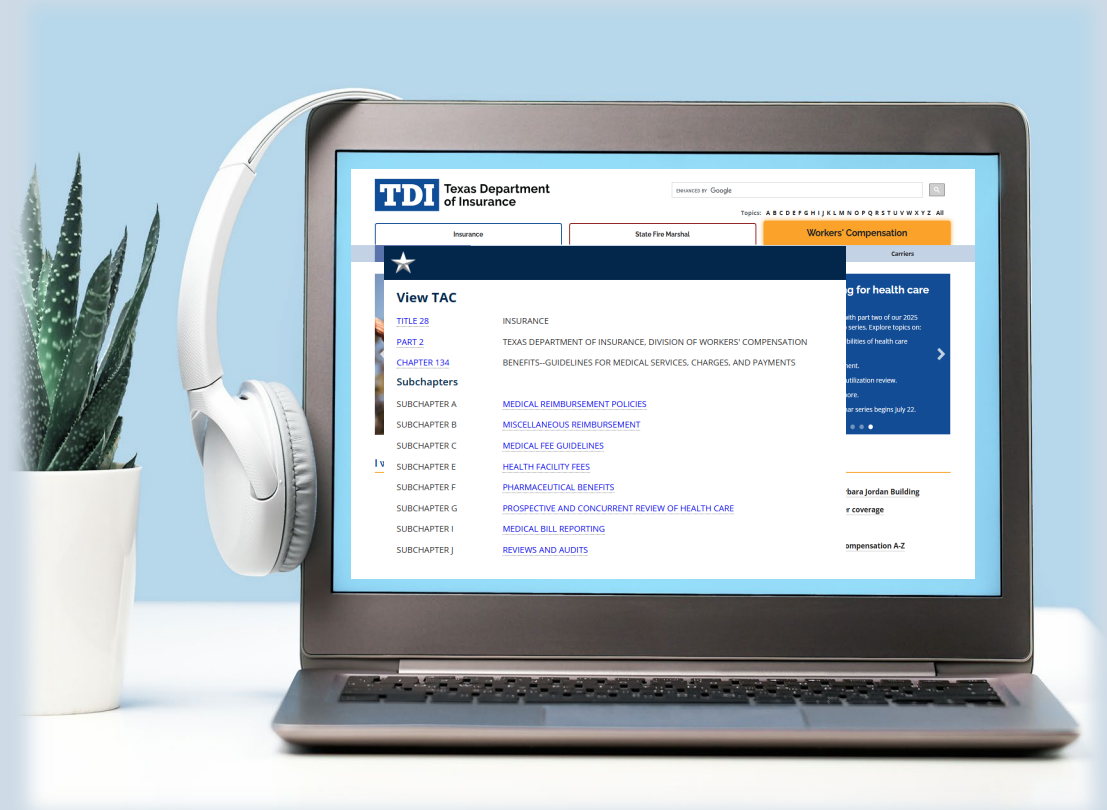


Benefits-Guidelines for Medical Services, Charges and Payments

28 TAC Chapter 134

28 TAC Chapter 134 Subchapters

- A. Medical Reimbursement Policies
- B. Miscellaneous Reimbursement
- C. Medical Fee Guidelines
- E. Health Facility Fees
- F. Pharmaceutical Benefits



Applicability

DWC fee guidelines:

- Apply to non-network health care.
- Do not apply to certified workers' compensation network (network) health care, except:
 - designated doctor (DD), required medical (RME) examinations, TD IR exams;
 - medical examinations for supplemental income benefits/treating doctor for compensable injury;
 - out-of-network health care provider approved by the network or an emergency;
 - health care for injured employees that do not live within the service area; and
 - pharmaceutical benefits.



Workers' Compensation Non-Network



Maximum allowable reimbursement (MAR) is:

The maximum amount payable to a health care provider in the absence of a contractual fee arrangement that is consistent with Labor Code Section (Sec.) 413.011 and the DWC rules.

Workers' Compensation Non-Network

Reimbursement for non-network health care shall be according to:

- DWC fee guidelines;
- negotiated contract; or
- if none of the above exists, a fair and reasonable reimbursement amount.

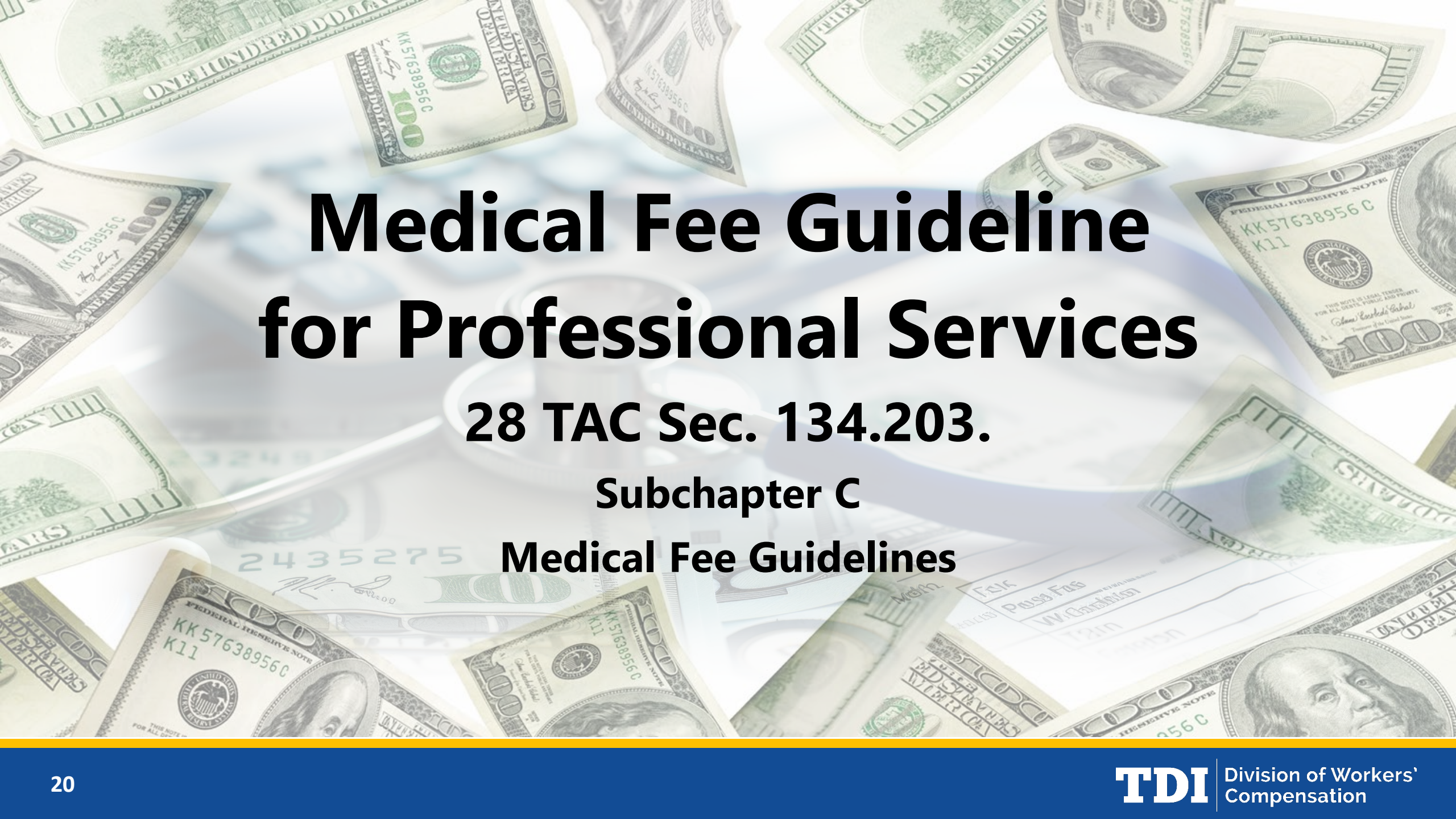


Fair and Reasonable Reimbursement

Should be consistent with Labor Code Sec. 413.011:

- ensures the quality of medical care;
- achieves effective medical cost control; and
- does not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living.



The background of the slide features a collage of US dollar bills, including \$100 and \$10 bills, scattered across the frame. A medical syringe is also visible, positioned diagonally across the center. The text is overlaid on this background.

Medical Fee Guideline for Professional Services

28 TAC Sec. 134.203.

Subchapter C

Medical Fee Guidelines

Applicability

28 TAC Sec. 134.203. Medical Fee Guideline for Professional Services applies to:

- dates of service on or after March 1, 2008; and
- professional medical services, except:
 - workers' compensation specific codes, services, and programs;
 - prescription drugs or medicine;
 - dental services; or
 - medical services provided through a network with exceptions.



Professional Services

Evaluation & Management

General Medicine

Physical Medicine and Rehabilitation

Radiology

DME Lab and Pathology

Anesthesia

Surgery performed in an office setting

Professional services related to a surgery performed in a facility



Applicable Payment Policies

For coding, billing, reporting and reimbursement of professional medical services, the following applies:

- Medicare coding; billing; NCCI edits; modifiers; HPSAs; PSAs; and other payment policies in effect on the date of service.
- Incentive payment of 10% added to the MAR for services provided in DWC designated workers' compensation underserved areas, 28 TAC Sec. 134.2.
- Any exceptions to Medicare payment policies by DWC rules.

28 TAC Sec. 134.203. Medical Fee Guideline for Professional Services (b)

Notable Exceptions to Medicare Policies

Medicare policies limit chiropractic services, however:

- Labor Code Sec. 413.011 (c) does not restrict the ability of chiropractors to serve as treating doctors.
- 28 TAC Sec. 134.203 (a)(6) allows chiropractors to provide services within their scope and practice.



Medicare Policy Changes



Occur automatically by DWC rule and apply:

- On or after the effective date of the Medicare policy; or
- After the effective date or the adoption date of the revised policy.
- Whichever is later.

28 TAC Sec. 134.203. Medical Fee Guideline for Professional Services (a)(8)

Examples of Medicare Payment Policies that Apply

Some current examples as of 2026*:

- Medicare multiple procedure payment reduction (MPPR) for select therapy services, surgery services and other applicable services.
- Medicare National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits, to determine appropriate use of 59 modifier.
- Functional reporting GN, GO, and GP modifiers for therapy services and CQ and CO for physical therapy assistants and occupational therapy assistants.
- CPT time rule applies for 15 minute timed physical therapy codes ≥ 8 minutes = 1 unit, < 8 minutes = no unit billed.

*subject to change if Medicare changes.

DWC and Medicare Conflicting Payment Policies

Labor Code and rules take precedence over any conflicting Medicare payment policies.

Some examples of conflicting Medicare policies that do not apply:

No physical therapy threshold caps or MUEs restricting # of units.

- Medically reasonable health care is not limited due to Labor Code 408.021. Entitlement to Medical Benefits.

No incident to billing.

- Licensed health care practitioners must submit their own bills due to 28 TAC 133.20. Medical Bill Submission by Health Care Provider.

No lesser of calculation.

- Nonphysician practitioner reimbursement due to Insurance Code 1451.104. Nondiscriminatory Payment or Reimbursement.

Correct Billing Codes

Professional medical bills relating to 134.203 require:

- Most current Level I (CPT codes) and Level II (HCPCs) codes.
- Select the billing code that best describes to the highest degree of specificity, the service being provided.

28 TAC Sec. 134.203. Medical Fee Guideline for Professional Services (i)

Correct Billing Codes

Workers' compensation specific services relating to [Rules 134.210-134.260](#) require:

- Most current Level I (CPT codes) and Level II (HCPCs) codes.
- Billing codes and modifiers as listed in the rules.

28 TAC Sec. 134.210. Medical Fee Guideline for Workers' Compensation Specific Services (b)

Selecting Levels of Evaluation and Management (E/M) Services

Select the appropriate CPT code level for E/M services based on:

1. The level of the medical decision making (MDM) as defined for each service, or
2. The total time for E/M services performed on the date of the encounter.

E/M CPT codes most often questioned:
99205 and 99215

[2023 CPT E/M descriptors and guidelines \(ama-assn.org\)](https://www.ama-assn.org/practice-management/cpt)

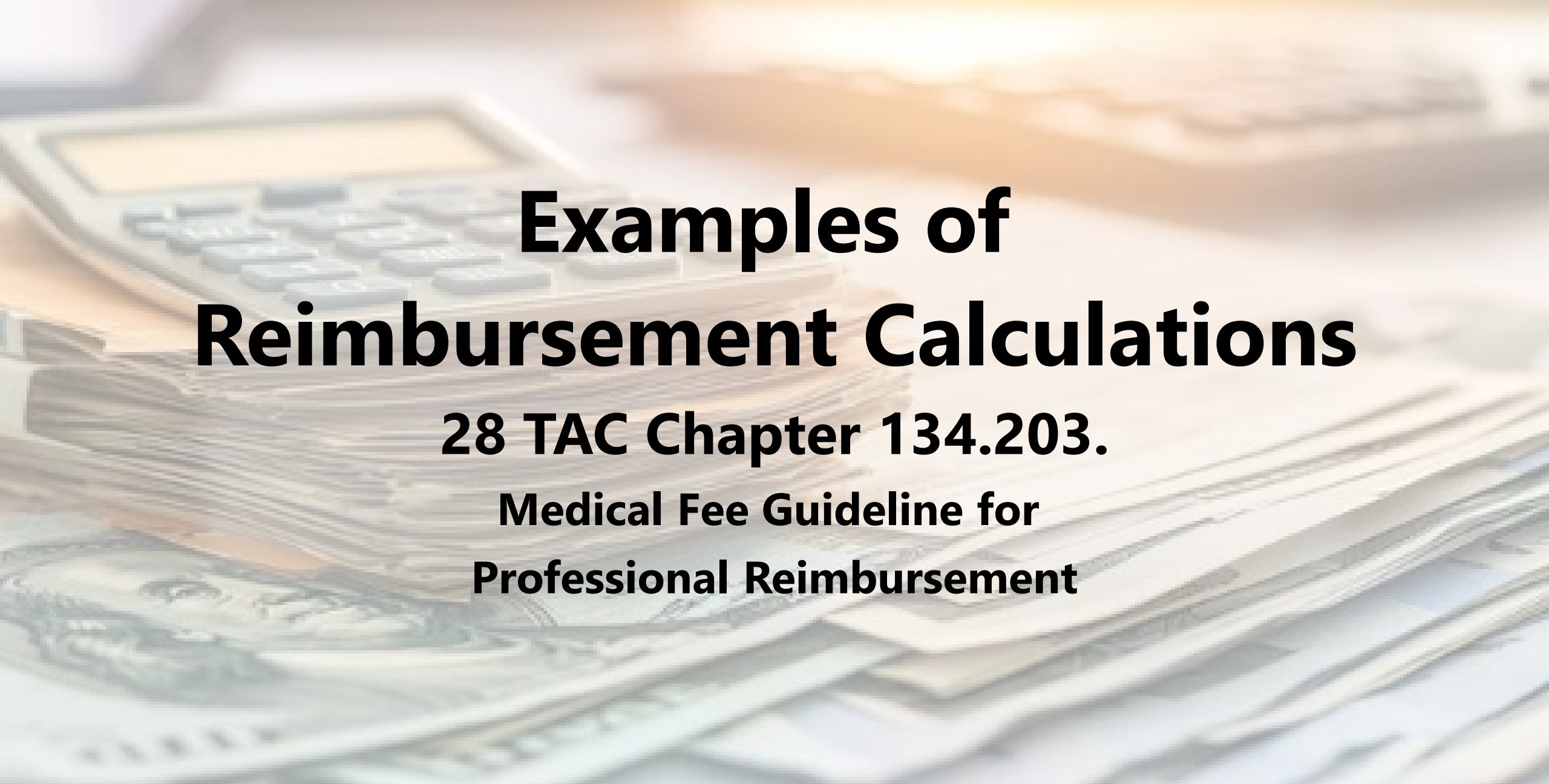
[MLN906764 Evaluation and Management Services Guide 2023-08 \(cms.gov\)](https://www.cms.gov/mcn906764)

Changing CPT or HCPCs Codes and Supporting Documentation

Best practices to avoid billing delays and denials:

- Select the CPT/HCPCs code that matches the services rendered to the highest degree of specificity (be careful not to up code).
- Ensure that the medical record documentation matches and supports the description of the billing code selected, **especially the exact start and end times** for timed CPT codes.
- Submit bill with the changed CPT/HCPCs code(s) within the billing deadline of 95 days from the date of service.
- Changing a CPT/HCPCs code does not reset your filing deadline of 95 days.





Examples of Reimbursement Calculations

28 TAC Chapter 134.203.

**Medical Fee Guideline for
Professional Reimbursement**

Service Categories

To calculate the MAR, apply the Medicare payment policies, with DWC modification, for the following professional service categories:

- Evaluation and Management
- General Medicine
- Physical Medicine and Rehabilitation
- Radiology
- Pathology
- Anesthesia
- Surgery (in office setting)
- Surgery (while patient is in facility)



Medicare's Reimbursement Methodology



$$\begin{aligned} & (\text{Work Expense} \times \text{Work GPCI}) \\ & + (\text{Practice Expense} \times \text{PE GPCI}) \\ & + \underline{(\text{Malpractice Expense} \times \text{MP GPCI})} = \\ & \quad \text{Total RVU} \\ & \underline{\times \text{Conversion Factor (CF)}} = \\ & \quad \text{Reimbursement Amount} \end{aligned}$$

DWC Specific Modification

Replace the Medicare CF with the applicable DWC CF in the reimbursement calculation.

DWC Conversion Factors

www.tdi.texas.gov/wc/fee/index.html#med

DWC CFs are based on the Medicare Economic Index (MEI) and reflect the annual changes of MEI.



DWC Conversion Factors

Conversion factors to be applied for services provided based on the following time frames

Applicable from	Applicable to	Anesthesia	Evaluation and management	General medicine	Pathology	Physical medicine and rehabilitation	Radiology	Surgery in an office setting	Surgery in a facility setting	MEI percentage adjustment
1/1/26	12/31/26	\$72.07	\$72.07	\$72.07	\$72.07	\$72.07	\$72.07	\$72.07	\$90.48	2.7%
1/1/25	12/31/25	\$70.18	 216% of Medicare	\$70.18	\$70.18	\$70.18	\$70.18	\$70.18	 272% of Medicare	3.5%
1/1/24	12/31/24	\$67.81	\$67.81	\$67.81	\$67.81	\$67.81	\$67.81	\$67.81	\$81.38	4.6%
1/1/23	12/31/23	\$64.83	\$64.83	\$64.83	\$64.83	\$64.83	\$64.83	\$64.83	\$81.38	3.8%

Medicare and DWC Reimbursement Methodology Compared

Medicare

$$\frac{(\text{Work} \times \text{GPCI}) + (\text{Practice} \times \text{GPCI}) + (\text{Malpractice} \times \text{GPCI})}{\text{Total RVU}} \times \text{Medicare CF} = \text{Medicare Reimbursement}$$

DWC

$$\frac{(\text{Work} \times \text{GPCI}) + (\text{Practice} \times \text{GPCI}) + (\text{Malpractice} \times \text{GPCI})}{\text{Total RVU}} \times \text{DWC CF} = \text{DWC Reimbursement (MAR)}$$

 **DWC modification**

Long Calculation Example Comparing Medicare and DWC

CPT code 99214 established patient visit, in Austin, Texas in 2026 (non-network):



Medicare

$$\begin{array}{r} (1.92 \times 1.002) \\ + (2.0 \times 1.058) \\ + (0.14 \times 0.886) \\ \hline 4.16388 \\ \times 33.4009 \\ \hline \$139.08 \end{array}$$

DWC

$$\begin{array}{r} (1.92 \times 1.002) \\ + (2.0 \times 1.058) \\ + (0.14 \times 0.886) \\ \hline 4.16388 \\ \times 72.07 \\ \hline \$300.09 \end{array}$$



Short Calculation

(DWC CF \$72.07 ÷ Medicare CF \$33.4009 = 2.16 or 216%)

x Medicare participating amount

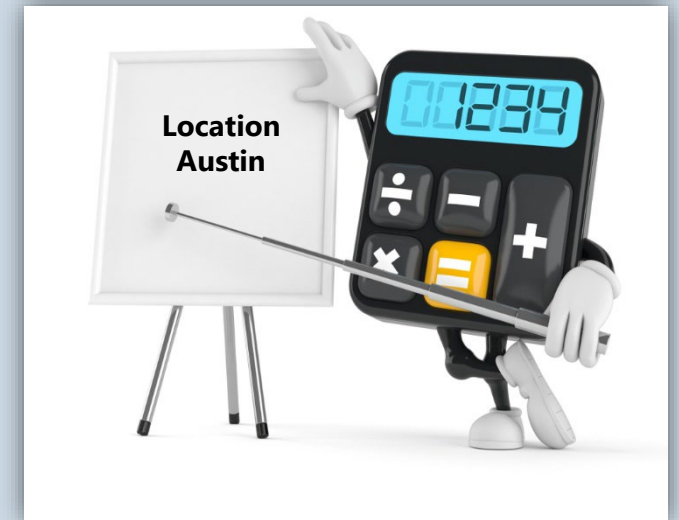
Approximate DWC Reimbursement



Short Calculation Example

CPT code 99214 established patient visit, in Austin, Texas in 2026:

$$\begin{array}{r} (\text{DWC CF} \div \text{Medicare CF}) \\ \times \text{Medicare Participating amount} \\ \hline \text{DWC MAR} \\ \\ (\$72.07 \div \$33.4009) = 216\% \\ \times \$139.08 \\ \hline \$300.41^* \end{array}$$



*Using the short calculation results in approximate amounts.

Reimbursement for Physician Assistants and Nurse Practitioners

- Reimbursement is the same methodology used for physicians, at 85%, and 85% of 16% for assistant-at-surgery services.
- Reimbursing a PA or NP at 80% of the actual charge is not the same methodology used for physician reimbursement and conflicts with Insurance Code 1451.104(c).
- In conflicts between Medicare and DWC, DWC laws and rules take precedence. Reimbursement for PAs and NPs is an exception to Medicare payment policies.

Labor Code 413.011 (c) and Insurance Code 1451.104 (c)

Medicare Reimbursement for Physician Assistants and Nurse Practitioners

CPT code 99213 provided by a PA or NP in Austin, Texas in 2026, non-network.

1. 2026 DWC CF is \$72.07.
2. 2026 Medicare CF is \$33.4009.
3. DWC CF divided by the Medicare CF is 216%.
4. Medicare locality is "Austin."
5. Medicare participating amount for CPT code 99213 at this locality is \$97.77.
6. 85% of the Medicare Physician Fee Schedule = Medicare participating amount of \$83.10.
7. DWC non-network MAR is $\$83.10 \times 2.16 = \179.50^* .

*short calculation results are approximations.

Other Categories

To calculate the MAR, for Health Care Common Procedure Code (HCPCs) beginning with A, E, J, K and L:

- 125% of Medicare's durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule;
- If code has no published Medicare rate, 125% of the Texas Medicaid fee schedule;
- If neither have a published rate, then apply 28 TAC Sec. 134.1. Medical Reimbursement.

Fair and Reasonable Reimbursement

28 TAC Rule 134.203 (f) states for those products or services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid, or the Division, reimbursement shall be provided in accordance with 134.1.

One example: CPT code **21899** Unlisted procedure, neck or thorax

NOTE: Ensure that you are selecting the billing code that follows Medicare reporting and coding guidelines and is most accurate and specific for the service you are providing.

Step #1, does Medicare value this service?

Check the CMS Medicare Administrative Contractor (MAC) Novitas-Solutions' fee schedule:

[Novitas-Solutions Fee Schedule Code Search & Downloads](#)

For exact URL:

<https://www.novitas-solutions.com/webcenter/portal/MedicareJH/FeeLookup>

Medicare does not value this service. (as of 6/16/2026)

NOVITAS SOLUTIONS

Medicare JH
Providers in AR, CO, LA, MS, NM, OK, TX, Indian Health & Veteran Affairs

[JH Home](#)

Medicare Part B [\[Change to A\]](#)

Physician's Fee Schedule Code Search & Downloads

Search using a single code

Procedure Code: 21899 No Modifier
Date Of Service: 5/8/2026
State: Texas
Locality: Austin (31)
[Search](#) [Clear](#)

Download the complete Fee Schedule

Year: 2026 - QPP
State: Choose a state...
Locality: Choose a locality...
File type: PDF
[Download](#)

Results

Procedure Code	21899	State	Texas	Modifier	No Modifier
Effective Date	01-01-2026	Locality	Austin (31)	Description	Unlisted px neck/thorax

Please click on the [?](#) icon for a description of any field or indicator

Fee Schedule Amount

Participating Provider	0.00
Non-Participating Provider	0.00
Limiting Charge Amount	0.00

When performed in a facility setting

Participating Provider	0.00
Non-Participating Provider	0.00
Limiting Charge Amount	0.00

Status Indicators

Home / All Tools

- [JH Home](#)
- [Novitasphere Portal](#)
- [Appeals](#)
- [CERT](#)
- [Claims](#)
- [Contact Us](#)
- [Learning Center](#)
- [Electronic Billing-EDI](#)
- [Enrollment](#)
- [Evaluation & Management](#)
- [Frequently Asked Questions](#)
- [Fee Schedules](#)
- [Home \(All Fees\)](#)
- [Search & Download Fee Schedules](#)
- [Flu, Pneumonia, and Hep B Fees](#)
- [Local Contractor Pricing](#)
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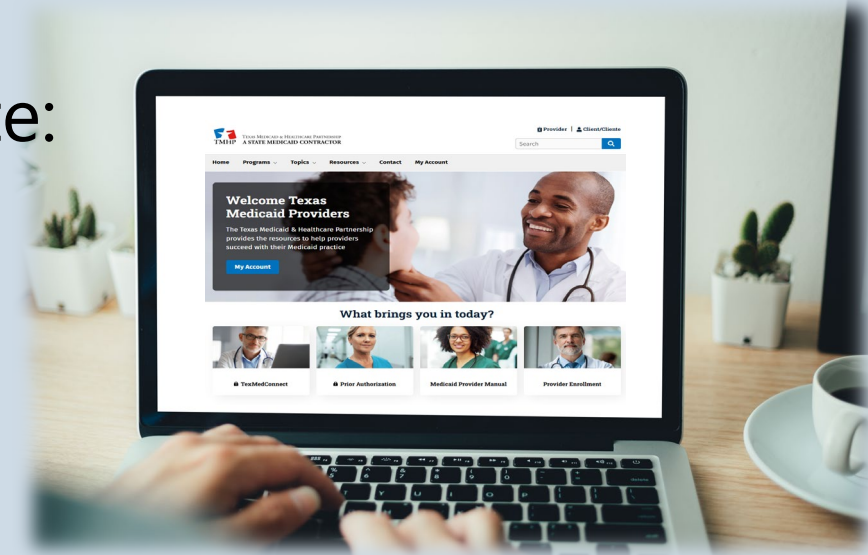
Step #2: Does Texas Medicaid value this service?

Check the Texas Medicaid contractor
Texas Medicaid Health Partners (TMHP) website:

[Welcome Texas Medicaid Providers | TMHP](https://public.tmhp.com/FeeSchedules/Default.aspx)

For exact URL:

<https://public.tmhp.com/FeeSchedules/Default.aspx>



Medicaid does not value this service. (as of 6/16/2026)

Use the static fee schedule under "Resources" for your provider type, in this example "physician":

01	2	SURGERY	21825			0	20	Years									16.81	\$28.0672	\$471.81	3/1/2026	0.00	\$471.81	10			3/1/2026	
02	2	SURGERY	21825			21	999	Years									16.81	\$26.7305	\$449.34	3/1/2026	0.00	\$449.34	10			3/1/2026	
03	2	SURGERY	21899			0	999	Years									0.00	\$0.0000	\$0.00	1/1/2010		\$0.00	5			3/1/2026	
04	2	SURGERY	21920			0	20	Years	7.64	\$28.0672	\$214.43	3/1/2026	0.00	\$214.43			4.70	\$28.0672	\$131.92	3/1/2026	0.00	\$131.92				3/1/2026	
05	2	SURGERY	21920			21	999	Years	7.64	\$26.7305	\$204.22	3/1/2026	0.00	\$204.22			4.70	\$26.7305	\$125.63	3/1/2026	0.00	\$125.63				3/1/2026	
06	2	SURGERY	21925			0	20	Years									11.61	\$28.0672	\$325.86	3/1/2026	0.00	\$325.86				3/1/2026	

Step #3: Does the Division value this service?

There is no Division rule that values CPT code 21899.



Step #4: Apply 28 TAC Rule 134.1.

Reimbursement shall be provided in accordance with
28 TAC 134.1. Medical Reimbursement.



Fair and Reasonable Reimbursement

28 TAC Sec. 134.1. Medical Reimbursement states:

Medical reimbursement for health care not provided through a workers' compensation network shall be made by:

- Division fee guidelines;
- Negotiated contract; or
- In the absence of above, a fair and reasonable amount.



Fair and Reasonable Reimbursement

28 TAC Sec. 134.1. Medical Reimbursement, states fair and reasonable shall be consistent with Labor Code 413.011 and:

- Ensures similar procedures provided in similar circumstances receive similar reimbursement.
- Based on:
 - Nationally recognized published studies;
 - Published DWC medical dispute decisions; or
 - Values assigned for services involving similar work and resource commitments, if available.

What is best practice in determining fair and reasonable reimbursement?

Best practice in seeking or reimbursing fair and reasonable, HCPs and workers' compensation insurance carriers should:

- Develop rationale or method that supports the amount you are seeking or reimbursing is fair and reasonable in a position statement.
- Accompany the position statement with supporting documentation that shows that the amount is consistent with Labor Code 413.011 and 28 TAC Sec. 134.1.
- Use this information in negotiating reimbursement, in writing:
 - **Before services are rendered (best option);**
 - During reconsideration; or
 - During dispute resolution.

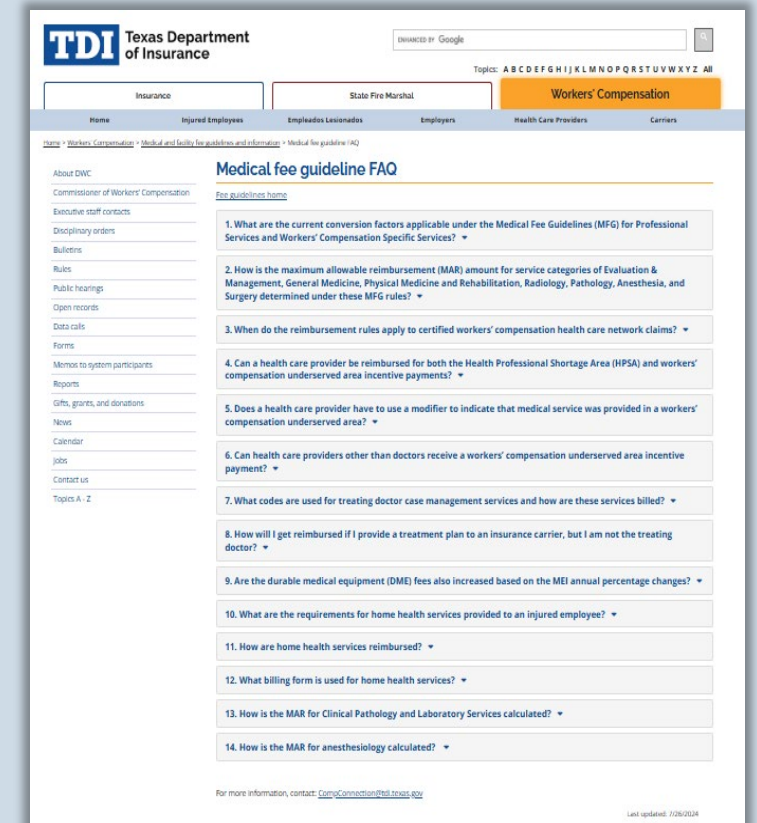


Medical Fee Guideline Resources

Medical Fee Guideline Frequently Asked Questions (FAQ) includes questions on:

- HPSAs and DWC incentive payments.
- DME fees and MEI.
- MAR for clinical pathology and laboratory services calculations.
- Anesthesiology calculations.
- Other topics.

<https://www.tdi.texas.gov/wc/fee/mfgfaq.html>



Medicare Payment Policies and Physician Fee Schedule

Centers for Medicare and Medicaid Services
Regulations and Guidance by Provider Type
www.cms.gov

CMS Medicare Physician Fee Schedule
www.cms.gov/apps.physician-fee-schedule/overview.aspx

[Novitas Solutions, Inc.](http://www.novitas-solutions.com/webcenter/portal/MedicareJH)
MAC for Texas Professional Services
www.novitas-solutions.com/webcenter/portal/MedicareJH

[CGS Medicare](http://www.cgsmedicare.com/medicare_dynamic/jc/hcpcs/search.aspx)
MAC for Texas DMEPOS
www.cgsmedicare.com/medicare_dynamic/jc/hcpcs/search.aspx

Medicaid Fee Schedules

Texas Medicaid Health Partners

www.tmhp.com

Online Fee Schedule Look Up: Static fee schedules

<https://public.tmhp.com/FeeSchedules/StaticFeeSchedule/FeeSchedules.aspx>



Workers' Compensation Specific Services

28 TAC Sec. 134.209. to 134.230.

Subchapter C

Medical Fee Guidelines

Medical Fee Guideline for Workers' Compensation Specific Services

- Descriptions of services;
- CPT codes;
- Required DWC modifiers; and
- Reimbursement amounts.



Medical Fee Guideline for Workers' Compensation Specific Services



28 TAC Sec. 134.209. Applicability, states these rules do not apply to:

- Professional services covered by 134.203;
- Prescription drugs or medicine;
- Facility services;
- Services provided through a network; and
- Other miscellaneous exceptions.

Medical Fee Guideline for Workers' Compensation Specific Services

28 TAC Sec. 134.210. Medical Fee Guideline for Workers' Compensation Specific Services, includes:

- Coding, billing, and reporting for workers' compensation specific codes, services, and programs;
- Which services are paid the DWC incentive payment; and
- List of DWC specific modifiers.

Medical Fee Guideline for Workers' Compensation Specific Services



28 TAC Sec. 134.215. Home Health Services

- Licensed home health agencies.
- 125% of the Texas Medicaid fee schedule for home health agencies.

Medical Fee Guideline for Workers' Compensation Specific Services

28 TAC Sec. 134.220. Case Management Services

- Case management services are for purposes of coordination of medical care and return to work options.
- Applies to treating doctor and referral health care provider.
- CPT codes, modifiers and reimbursement amounts provided in rule.

Medical Fee Guideline for Workers' Compensation Specific Services

Case management services include:

- Requiring the use of 2007 American Medical Association CPT codes (deleted by AMA) 99361, 99362, 99371, 99372, and 99373.
- CPT code service descriptions are listed in the [Medical Fee Guideline Frequently Asked Questions](#) #7.
- Team conferences and telephone calls with an outside interdisciplinary team.
- Documentation should support the services and CPT code billed.

Medical Fee Guideline for Workers' Compensation Specific Services

Case management services example:

CPT code: 99362 with W1 modifier

Description: Medical conference by a physician with interdisciplinary team of health professionals or representative of community agencies to coordinate activities of patient care (patient not present): approximately 60 minutes.

Reimbursement: Treating doctor = \$198, contributing health care provider (no modifier) = \$50.

Medical Fee Guideline for Workers' Compensation Specific Services

28 TAC Sec. 134.225. Functional Capacity Evaluations (FCE)

- Only 3 FCEs allowed per claim, DWC ordered FCEs do not count towards the 3.
- CPT code 97750 modifier FC
- Billed per hour with a maximum of:
 - 4 hours for initial test or for DWC ordered test.
 - Maximum of 2 hours for an interim test.
 - Maximum of 3 hours for a discharge test, unless it is the initial test.
- Reimbursement found in 28 TAC Sec.134.203. Medical Fee Guideline for Professional Services.
- Documentation is required and outlined in rule.

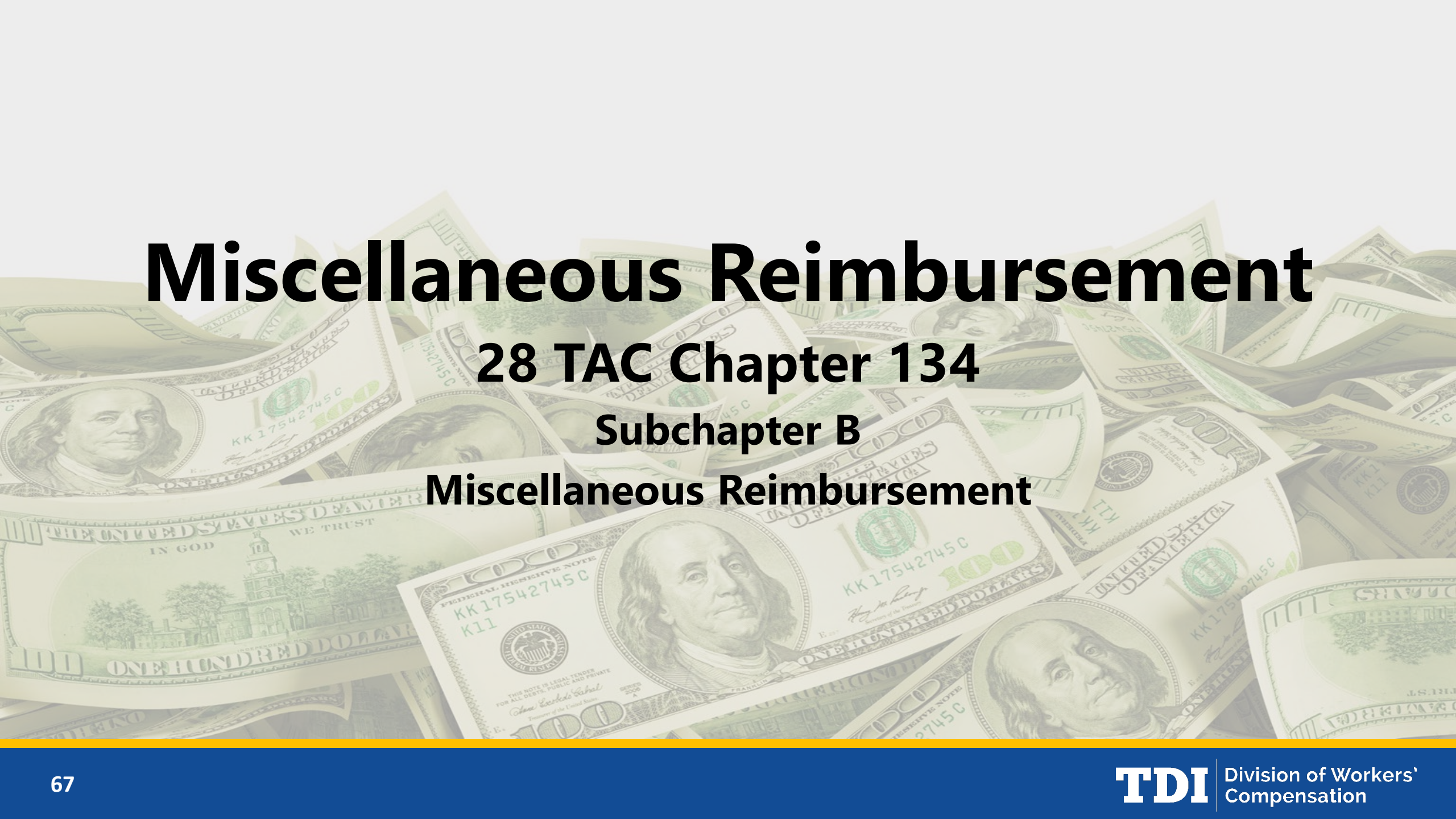
Medical Fee Guideline for Workers' Compensation Specific Services

28 Sec. 134.230. Return to Work Rehabilitation Programs

- ✓ Work Conditioning
- ✓ Work Hardening
- ✓ Chronic Pain Management Programs
- ✓ Outpatient Medical Rehabilitation Programs

Commission on
Accreditation of
Rehabilitation
Facilities (CARF)

- Accreditation by CARF is recommended but not required.
- CPT codes and modifiers are listed and billed per hour.
- CARF programs use CA modifier and receive 100% of the MAR.
- Non CARF programs do not use the CA modifier and receive 80% of the MAR.

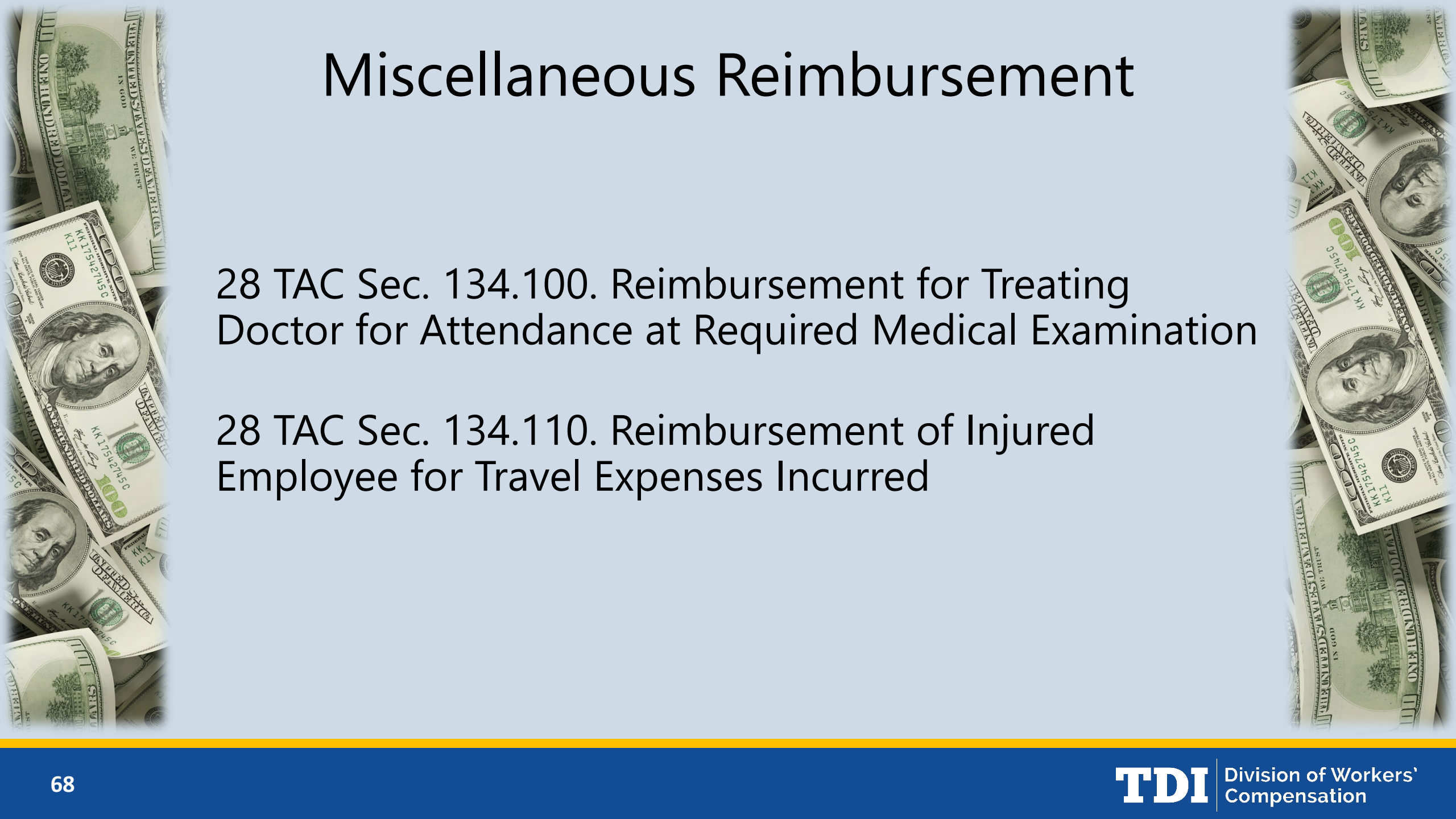


Miscellaneous Reimbursement

28 TAC Chapter 134

Subchapter B

Miscellaneous Reimbursement

A decorative border composed of various US dollar bills, including \$100 and \$500 bills, is visible on the left and right sides of the slide. The bills are partially overlapping and show details like the portrait of Benjamin Franklin and the text 'ONE HUNDRED DOLLARS' and 'FEDERAL RESERVE NOTE'.

Miscellaneous Reimbursement

28 TAC Sec. 134.100. Reimbursement for Treating Doctor for Attendance at Required Medical Examination

28 TAC Sec. 134.110. Reimbursement of Injured Employee for Travel Expenses Incurred

Miscellaneous Reimbursement

28 TAC Sec. 134.120. Reimbursement for Medical Documentation

- Insurance carrier not required to reimburse the initial copy of medical documentation.
- Injured employee or representative is entitled to the initial copy of medical documentation without charge.
- Requestor must reimburse subsequent copies.
- Reimbursement amounts in rule.
- For medical records sent to a DD, 28 TAC Sec. 127.10 states reimbursement shall be in accordance with Rule 134.120.



Reimbursement for Records Provided to the Office of Injured Employee Counsel (OIEC)



28 Part 6 TAC Sec. 276.11. Access to Injured Employee Medical Documentation

A health care provider's reimbursement from an insurance carrier for costs of documentation provided to OIEC are prescribed by the provisions of:

28 TAC Sec. 134.120. Reimbursement for Medical Documentation.

Reimbursement for Records Provided to a Designated Doctor

28 TAC Sec. 127.10. General Procedures for Designated Doctor Examinations

A treating doctor may be reimbursed by the insurance carrier for the cost of copying the injured employee's medical records sent to the designated doctor in accordance with:

28 TAC Sec. 134.120. Reimbursement for Medical Documentation.



Interest for Late Payments



28 TAC Sec. 134.130. Interest for Late Payment on Medical Bills and Refunds

- Insurance carriers must pay interest on medical bills paid on or after the 60th day after the insurance carrier originally received the complete medical bill.
- Health care providers shall pay interest to insurance carrier on requests for refunds paid later than the 60th day after the date the refund request was received.

Interest for Late Payments



28 TAC Sec. 134.130. Interest for Late Payment on Medical Bills and Refunds

- Interest rate will be determined according to Labor Code Sec. 401.023.
- DWC publishes the interest rate quarterly.

Interest for Late Payments

28 TAC Sec. 134.130. Interest for Late Payment on Medical Bills and Refunds

Calculate the interest as follows:

- Multiply the rate of interest by the amount on which interest is due (to determine the annual amount of interest);
- Divide the annual amount of interest by 365 (to determine daily interest amount); and
- Multiply the daily interest amount by the number of days the interest is owed.



Interest for Late Payments

DWC Resources for interest payments:

- Interest rates published on DWC website in a table

www.tdi.texas.gov/wc/carrier/disint.html#interestrates

- Interest rate calculator (excel calculator)

www.tdi.texas.gov/wc/carrier/disint.html#calculator

NOTE: Instructions on first tab, calculator on second tab, and interest rates on last tab.





Recap

Chapter 134, Benefits-Guidelines for Medical Services,
Charges and Payments. ✓

Medical Fee Guideline for Professional Services. ✓

Reimbursement Calculation Examples. ✓

Fair and Reasonable Reimbursement. ✓

Workers' Compensation Specific Services. ✓

Miscellaneous Reimbursement. ✓

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