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

Requestor Name
Texas Midwest Surgical Center

Respondent Name
Everest National Insurance Co

MFDR Tracking Number
M4-25-1045-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
January 14, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 1, 2024	36415	$25.52	$0.00
March 1, 2024	84132 QW	$203.04	$0.00
March 5, 2024	29880LT	$9936.94	$0.00
March 1, 2024	93005	$544.13	$0.00
	Total	$10,709.63	$0.00

Requestor's Position

"The above reference bill was referred to Knowtion Health to assist in resolving an outstanding payment issue on behalf of TEXAS MIDWEST SURGERY CENTER. The bill was not paid as expected due to a denial issued by GALLAGHER BASSETT. We demand overturning this wrongful denial by virtue of this medical fee dispute."

Amount in Dispute: $10,709.63

Respondent's Position

The Austin carrier representative for Everest National Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on January 23, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within

14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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 133.10 sets out the requirements of ambulatory surgical center medical bill submission.

3. 28 TAC 134.203 details the requirements of coding, billing and reporting of medical bill submission.

Denial Reasons

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

- 5721 – To avoid duplicate bill denial for all reconsiderations/adjustments/additional payment requests, sbmit a copy of the EOR or clear notati(illegible)
- 90202 – Previously paid. Payment for this clam/service may have been provided in a previous payment.
- 5721 – To avoid duplicate bill denial, for all reconsiderations/adjustments/additional payment requests, submit a copy of this EOR or clear notation that a recon is
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 247 – A payment or denial has already been recommended for this service.

Issues

1. Was the medical claim in dispute submitted per applicable DWC rules?

Findings

1. The requestor seeks payment of surgical services rendered in March of 2024. The medical bill submitted with the request for MFDR was submitted on CMS-1450 (UB-04) with a bill type of 131 listed in box 7.

The NPI look-up at https://npiregistry.cms.hhs.gov/provider-view/1700887155listed in box 56 is 1700887155 found this NPI is for Texas Midwest Surgery Center, LLC with a taxonomy of 261QA19036X – Clinic/Center – Ambulatory Surgical. Review of Texas DSHS license look up at https://vo.ras.dshs.state.tx.us/datamart/detailsTXRAS.do?anchor=5745b2e.0.11 found the address listed for the requestor is for an Ambulatory Surgical Center.

DWC Rule 133.20 (f)(1) states in pertinent part, "The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care…"

The CMS Medicare Claims Processing Manual at www.cms.gov, Chapter 14, Section 50 states, "ASC Procedures for Completing the ASC x 12 837 Professional Claim Format or the Form CMS-1500.

DWC Rule 134.203 (b)(1) states in relevant parts, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing…"

Based on the rules and Medicare payment policies shown above, the medical bill should have been submitted on a CMS 1500 claim form not the CMS-1450. Additionally, the reported type of service "131" indicates, hospital outpatient claim. As the rendering facility is a licensed ambulatory surgical facility, bill type "131" is not valid. No 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 requestor has not established that reimbursement is due.

Order

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

Authorized Signature

	Medical Fee Dispute Resolution Officer	April 16, 2025
Signature		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 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 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 tres o correo electronico CompConnection@tdi.texas.gov.