TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Legent Interventional Pain

Respondent Name
Tarrant County

MFDR Tracking Number
M4-25-1068-01

Carrier's Austin Representative
Box Number 43

DWC Date Received
January 22, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 7, 2024	CPT 62362, C1772	$4,777.16	$0.00

Requestor's Position

Excerpt from Appeal to insurance carrier dated November 8, 2024: "You only paid us $15,835.74. We are owed $4,777.16 for being in-compliance with the TX WC FS rules regulations and administrative codes."

Amount in Dispute: $4,777.16

Respondent's Position

The Austin carrier representative for Tarrant County is Sedgwick York Risk Services. The representative was notified of this medical fee dispute on January 28, 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) §133.2 provides definitions for medical billing and processing rules.
2. 28 TAC §133.10 sets out the procedures for required billing forms/formats.
3. 28 TAC §133.200 sets out the procedure for medical bill processing/audit by insurance carrier.
4. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Adjustment Reasons

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

- 16 – Claim/service lacks information or has submission/billing error(s).
- 193 - Original payment decision Is being maintained. Upon review, it was determined that this claim was processed properly.
- 97 - The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- W3 - TDI Level 1 appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title.
- 4123 - ALLOWANCE IS BASED ON TEXAS ASC DEVICE INTENSIVE PROCEDURE CALCULATION AND GUIDELINES.
- 4915 - THE CHARGE FOR THE SERVICES REPRESENTED BY THE CODE IS INCLUDED/BUNDLED INTO THE TOTAL FACILITY PAYMENT AND DOES NOT WARRANT A SEPARATE PAYMENT OR THE PAYMENT STATUS INDICATOR DETERMINES THE SERVICE IS PACKAGED OR EXCLUDED FROM PAYMENT.
- 983 - CHARGE FOR THIS PROCEDURE EXCEEDS MEDICARE ASC SCHEDULE ALLOWANCE.
- 97 - PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- N702 - Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
- N800 - Adjusted based on the applicable fee schedule for the region in which the service was rendered.

- N706 – Missing documentation.
- MA46 – The new information was considered but additional payment will not be issued.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 226 – INFORMATION REQUESTED FROM THE BILLING/RENDERING PROVIDER WAS NOT PROVIDED OR NOT PROVIDED TIMELY OR WAS INSUFFICIENT/INCOMPLETE.
- W3 – BILL IS A RECONSIDERATION OR APPEAL.
- M29 – Missing operative report/note.

Issues

1. Did the requestor submit a complete medical bill for the services in dispute?

2. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. DWC Rules require that health care providers submit complete medical bills for reimbursement of medical services.

   28 TAC §133.2(4) defines a "complete medical bill" as "A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter …, or as specified for electronic medical bills in §133.500 of this chapter…"

   28 TAC §133.10(f)(1) (AA) states, "service facility location information (CMS-1500/field 32) is required."

   A review of the medical bills submitted finds that field 32 of the CMS-1500 medical bill form submitted is blank with no facility location information present on the CMS-1500 medical billing form as required by 28 TAC §133.10(f)(1) (AA). The service facility location information is required for DWC to determine the appropriate medical fee reimbursement and whether the insurance carrier paid for the disputed services according to the fee guideline.

   DWC finds that the requestor did not submit a complete medical bill, in accordance with 28 TAC §133.10, for the services in dispute.

2. The requestor is seeking additional reimbursement in the amount of $4,777.16 for services rendered on May 7, 2024.

   In its review of the submitted documentation, DWC found no evidence to support that the requestor submitted a complete medical bill to the insurance carrier in accordance with 28 TAC §133.10(f), for the services in dispute.

   For this reason, DWC finds that the requestor is not entitled to additional reimbursement for the services rendered on May 7, 2024.

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 additional reimbursement is due.

Order

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

Authorized Signature

		April 9, 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, 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.