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
Legent Outpatient Surgery
Austin

Respondent Name
Work First Casualty Co

MFDR Tracking Number
M4-25-1930-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
April 17, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 16, 2024	29888	$623.44	$0.00
September 16, 2024	C1762	$0.00	$0.00
September 16, 2024	C1713	$0.00	$0.00
	Total	$623.44	$0.00

Requestor's Position

"We are expecting $623.44 in additional payment. We have requested separate reimbursement for the implant. As per TDI Guidelines we are entitled to request and receive this reimbursement."

Amount in Dispute: $623.44

Respondent's Position

"Broadspire on behalf of Work First Casualty Co has received the above captioned Medical Fee Dispute Resolution. The bill has been reviewed again, and we have determined nothing further is due. Please refer to the attached EOB."

Response submitted by: Broadspire

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §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) §133.10 sets out the required billing forms and formats of medical bills.

2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

3. 28 TAC §134.402 sets out the billing guidelines for ambulatory surgical centers.

Denial Reasons

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

- BT100: Unless otherwise specified, services have been reviewed to the State Fee Schedule.
- BT975 – No additional allowance is recommended.
- BTRELIH – network reductions outside of the fee schedule taken through Reliant Health.
- TX193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- TX45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Did the requestor submit the medical bill on the required form?

Findings

1. The requestor has submitted a request for MFDR for ambulatory surgical services rendered in September of 2024. The insurance carrier made a payment of $8,539.00 and maintained their payment upon reconsideration and response to MFDR.

   DWC Rule §133.10 (f)(1)(A) – (EE) detail the billing requirements of noninstitutional medical bills. The required billing form is the CMS1500. The section of the 1500 claim form that must be completed to request separate implant reimbursement is 24-d – 24h.

   Review of the submitted medical bill found a CMS1450 form with a line that indicates,

"SEPARATE REIMBURSEMENT FOR IMPLANTS REQUESTED."

DWC Rule §134.402 (d) states, "For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided…"

The CMS Internet only manual at www.cms.gov, states in Chapter 14 Section 50 states, "ASC Procedure for Completing the ASC X12 837 Professional Claim Format or the Form **CMS-1500**. The Place of Service (POS) code is 24 for procedures performed in an ASC."

Based on our review, DWC finds the submitted medical bill for the disputed service was not submitted on the required form per the applicable Medicare payment policy and DWC Rule(s). No additional reimbursement 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 requester 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 reimbursement for the disputed services.

Authorized Signature

		May 22, 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, please call CompConnection at 1-800-252-7031, option 3 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 3 o correo electronico CompConnection@tdi.texas.gov.