



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Legent Outpatient
Surgery Austin

Respondent Name

Sompo America Fire & Marine Insurance Co

MFDR Tracking Number

M4-25-2168-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

May 8, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 2, 2024	29827	\$1204.08	\$0.00
December 2, 2024	C1713	Left blank	\$0.00
Total		\$1204.08	\$0.00

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration that states, "We are expecting \$1204.08 in additional payment. We have requested separate reimbursement for the implant."

Amount in Dispute: \$1204.08

Respondent's Position

The Austin carrier representative for Sompo America Fire & Marine Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on May 13, 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 \(TAC\) §133.305](#) sets out the procedures for resolving medical disputes.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §133.10](#) sets out the required billing forms and formats of ambulatory surgical center claims.
4. [28 TAC §134.402](#) sets out the billing guidelines for ambulatory surgical centers.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Did the insurance carrier submit the medical bill per applicable DWC claim filing instructions?

Findings

1. DWC Rule §134.402 (d) 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...

DWC Rule §134.402 (b)(6) defines "Medicare payment policy" as reimbursement methodologies, models, and values or weights including its coding, billing and report payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

Review of the submitted documentation found the original medical bill was submitted on the form CMS 1450. The definition of this form at [Institutional paper claim form \(CMS-1450\) | CMS](#) indicates this form is to be used by institutional provider.

The Medicare Claims Processing Manual, Chapter 14, Section 50, at www.cms.gov states, 50 - ASC Procedures for Completing the ASC X12 837 Professional Claim Format or the Form CMS-150.

DWC Rule 133.10 (f) states All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1) The following data content or data elements are required for a complete professional...

Based on the applicable Medicare payment policy the services rendered by Legent Outpatient Surgery Austin are considered professional charges and should have been submitted on a CMS 1500.

Conclusion

Based on the evidence presented by both the requester and respondent at the time of adjudication, and upon review of applicable Texas Workers' Compensation rules and Medicare policies, the Division of Workers' Compensation finds:

- The billed services were not submitted per DWC billing guidelines.
- Therefore, the requester is not entitled to any additional reimbursement, and the amount due is \$0.00.

Although not all submitted evidence is discussed in detail, it was fully considered in reaching this determination.

Order

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

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July 30, 2025

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 electrónico CompConnection@tdi.texas.gov.