



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Memorial Hermann
Surgery Center Woodlands

Respondent Name

Deep East Texas Self Insurance

MFDR Tracking Number

M4-25-3065-01

Carrier's Austin Representative

Box Number 44

DWC Date Received

July 24, 2025

Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|------------------|-----------------------------|-------------------|------------|
| January 9, 2025 | Ambulatory Surgery Services | \$17,618.92 | \$0.00 |

Requestor's Position

"We do not agree with the denial. The carrier changed claims administrators from Tristar to Injury Management Organization. During the admission process we were advised that claims should be sent to Tristar for processing."

Amount in Dispute: \$17,618.92

Respondent's Position

"The providers submitting an Ambulatory Surgical bill on UB04. Our records indicate this bill has been returned to the provider 4 times. Requesting proper form CMS1500."

Response submitted by: Injury Management Organization (IMO)

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.

Adjustment Reasons

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

- TX29 - The time limit for filing has expired.
- 108 - No reimbursement is recommended as bill was not received within timely submission requirements.

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 on January 9, 2025.

DWC Rule §133.10 (f)(1)(A) – (EE) detail the billing requirements of noninstitutional medical bills. The required billing form is the CMS1500.

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, "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).

Evidence submitted supports that the insurance carrier returned the medical bill and notified the requester of the incorrect billing form giving the requester an opportunity to resubmit the claim on the correct form. A review of the submitted documents finds no evidence that the requester resubmitted the disputed claim on the correct billing form per the applicable Medicare payment policy and DWC Rule(s).

Reimbursement is not 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

| | | |
|---|--|----------------------------------|
|  _____ Signature | Ginger Ross _____ Medical Fee Dispute Resolution Officer | August 27, 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 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 electrónico CompConnection@tdi.texas.gov.