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

General Information

Requester Name
St Lukes Baptist

Respondent Name
Hartford Insurance Co of Illinois

MFDR Tracking Number
M4-25-3173-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
August 1, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 24, 2025	250	$0.00	$0.00
April 24, 2025	C1763	$2382.99	$0.00
April 24, 2025	64719-XU, RT	$170.64	$0.00
April 24, 2025	25115-RT	$0.00	$0.00
April 24, 2025	64721-XU, RT	$0.00	$0.00
April 24, 2025	370	$0.00	$0.00
April 24, 2025	J0131	$0.00	$0.00
April 24, 2025	J0665	$0.00	$0.00
April 24, 2025	J0690	$0.00	$0.00
April 24, 2025	J1100	$0.00	$0.00
April 24, 2025	J1171	$0.00	$0.00
April 24, 2025	J1308	$0.00	$0.00
April 24, 2025	J1885	$0.00	$0.00
April 24, 2025	J2003	$0.00	$0.00
April 24, 2025	J2250	$0.00	$0.00
April 24, 2025	J2405	$0.00	$0.00
April 24, 2025	J2704	$0.00	$0.00
April 24, 2025	J3010	$0.00	$0.00
April 24, 2025	J7050	$0.00	$0.00
	Total	$2,553.63	$0.00

Requester's Position

The requester did not submit a position statement. They did submit a copy of a document titled "Reconsideration" dated June 13, 2025 that states, "…After reviewing the payment, we realized that there is an underpayment for outpatient services, due to implant charges being bundled. Since implant charges were billed, reimbursement is based off the implant invoice and contracted amount."

Amount in Dispute: $2,553.63

Respondent's Position

"The original bill for dos 4/24/25 was received on 5/12/23 under control number 222582726 and paid per OPPS fee schedule in the amount of $3669.22. Partial denial as charges included/bundled into the total facility payment and does not warrant a separate payment."

Response submitted by: The Hartford

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

- 28 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.
- 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
- 28 TAC §134.403 sets out the rules and fee guidelines for outpatient hospital services.

Denial Reasons

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

- 97 – Payment adjusted because the benefit for this service in included in the payment/allowance for another service/procedure that has already been adjudicated.
- 602 – Charge for this procedure exceeds the OPPS schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 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.

Issues

1. Did the requester support a contract with Hartford Workers Comp?
2. Was separate payment of implants requested?
3. What is the rule applicable to reimbursement?
4. Is the requester entitled to additional reimbursement?

Findings

1. The requester indicates a contract between themselves, and Hartford Workers Comp dictates the payment of this medical claim. Insufficient evidence was found to support a contract or payment agreement. The disputed services will be reviewed per applicable DWC fee guidelines pertaining to workers compensation participants in the state of Texas.

2. The requester submitted a request for medical fee dispute for outpatient hospital charges rendered on April 24, 2025. Within their reconsideration, the requester indicates, "since implant charges were billed, reimbursement is based off the implant invoice and contracted amount. As stated above, the request did not support a contracted amount.

   DWC Rule TAC §133.10 (QQ) states, "remarks (UB-04/filed 80) is required when separate reimbursement for surgically implanted devices is requested.

   Review of the submitted UB-04 found no request for separate implant reimbursement was made, the rules and fee guidelines associated with implants do not apply to this medical bill.

   The disputed charges will be reviewed and fees calculated for outpatient hospital services when separate reimbursement of implants is **NOT** requested.

3. DWC Rule 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

   DWC Rule 28 TAC §134.403 (e)(2) states in pertinent part, regardless of billed amount, if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

   DWC Rule 28 TAC §134.403 (f) states in pertinent part the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*.

The sum of the Medicare facility specific reimbursement amount and any applicable outlier

payment amount shall be multiplied by: (A) 200 percent; Review of the submitted documentation found no evidence of a contract and the submitted medical bill did not contain a request for separate implant reimbursement.

The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non-labor portion determines the Medicare specific amount. Review of the submitted medical bill and the applicable fee guidelines referenced above are shown below.

- Procedure code 25115 has a status indicator of J1. The applicable Medicare payment policy for comprehensive procedures allows payment of only the highest ranked procedure. Review of the applicable Addenda J1 at www.cms.gov found code 25115 has a ranking of 3,066. This is not the highest ranked J1 procedure and is packaged into primary J1 procedure 64719.
- Procedure code 64719 has status indicator J1, for procedures paid at a comprehensive rate. This code has a ranking of 2,856 and is the highest ranked J1 procedure. This code is assigned APC 5431. The OPPS Addendum A rate is $1,952.77 multiplied by 60% for an unadjusted labor amount of $1,171.66, in turn multiplied by facility wage index 0.8983 for an adjusted labor amount of $1,052.50.

  The non-labor portion is 40% of the APC rate, or $781.11.

  The sum of the labor and non-labor portions is $1,833.61.

  The Medicare facility specific amount is $1,833.61 multiplied by 200% for a MAR of $3,667.22.
- Procedure code has a status indicator of J1 and a ranking of 2,874. This is not the highest ranked J1 procedure and is packaged into primary J1 procedure 64719.

4. The total recommended reimbursement for the disputed services is $3,667.22. The insurance carrier paid $3,669.22. Additional payment 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 of $2,553.63 is due.

Order

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

Authorized Signature

		August 25, 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.