



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Crescent Medical Center
Lancaster

Respondent Name

Zurich American Insurance Co

MFDR Tracking Number

M4-25-3274-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

August 14, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 17, 2025	29827-RT	\$4294.81	\$0.00
June 17, 2025	29823-RT	\$0.00	\$0.00
June 17, 2025	C1713	\$0.00	\$0.00
June 17, 2025	ALL OTHER	\$0.00	\$0.00
Total		\$4294.81	\$0.00

Requester's Position

"Zurich allowed \$9608.60. We did not request separate payment for implants. The expected allowed/MAR was \$13,903.41. Please pay the additional \$4,249.81."

Amount in Dispute: \$4294.81

Respondent's Position

"The carrier has reprocessed the provider's medical bill. We are attaching a copy of the carriers EOBs dated August 20, 2025, that recommends payment of an additional \$4,131.94. It is the carrier's position that the provider is entitled to a total payment of \$13,741.19. ...No additional monies are owed beyond the amounts identified in the carrier's most recent EOB dated August 20, 2025."

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 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:

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 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 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What is the rule applicable to reimbursement?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking payment of outpatient hospital charges rendered on June 17, 2025. The insurance carrier reduced the allowed charges based on fee schedule and packaging. 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*.

- (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 200 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement...

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 29827 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5114. The OPPS Addendum A rate is \$7,143.73 multiplied by 60% for an unadjusted labor amount of \$4,286.24, in turn multiplied by facility wage index 0.9362 for an adjusted labor amount of \$4,012.78. The non-labor portion is 40% of the APC rate, or \$2,857.49. The sum of the labor and non-labor portions is \$6,870.27. The Medicare facility specific amount is \$6,870.27 multiplied by 200% for a MAR of \$13,740.54.

2. The total recommended reimbursement for the disputed services is \$13,740.54. The insurance carrier paid \$9,608.60 at the original adjudication and then an additional \$4,131.94 for a total of \$13,740.54. 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 Crescent Medical Center Lancaster has not established that additional reimbursement 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

Signature

Medical Fee Dispute Resolution Officer

September 5 , 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.