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

General Information

Requester Name
Crescent Medical Center Lancaster

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-25-3319-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
August 19, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 8, 2025	49594	$2,833.01	$2,700.00
April 8, 2025	C1781	Unidentified	$0.00
April 8, 2025	ALL OTHER	Unidentified	$0.00
	Total	$2,833.01	$2,700.00

Requester's Position

"We did not request separate payment for implants. The expected allowed is $11,355.06".

Supplemental response December 12, 2025

"…In looking at the attachment received from Gallagher; it appears the check was mailed to PA Surgical. This is not Crescent Regional Hospital".

Amount in Dispute: $2,833.01

Respondent's Position

"Our supplemental response for the above referenced medical fee dispute resolution is as follows: The bill(s) in question was/were escalated and a review completed. Our bill audit company has determined that additional monies are owed in the amount of $2834.01. Interest in the amount of $49.75 has been added. Attached are an updated copy of the Explanation of Benefits and payment summaries for your records".

Response submitted by: Gallagher Bassett

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 §133.10 sets out the requirements of separate implant requests.
- 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:

- 197-5 – Precertification/authorization/notification/pre-treatment absent.
- 45-1 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 97-1 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12-3 – Workers' compensation jurisdictional fee schedule adjustment.
- P5-1 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
- TX353- This charge was reviewed according to the submitted invoice and documentation
- TX360 – Allowance for this procedure was made at the usual and customary amount for this geographical area.
- TX370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- TX616 – This code has a status Q APC indictor and is packaged into other APC codes that have been identified by CMS.

- TX618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- TX975- This line item was reviewed using the Fair Health charge benchmark databased module based on the provider geographic area.
- XXU00 – There was no UR procedure/treatment request received.

Issues

1. Are the insurance carrier's reductions supported?
2. What is the rule applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking additional payment of outpatient hospital charges rendered on April 8, 2025. The insurance carrier made payment on codes C1781 and 49594.

   Code C1781 represents implants. 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.

2. 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 49594 has status indicator J1. This code is assigned APC 5361. The OPPS Addendum A rate is $5,834.36 multiplied by 60% for an unadjusted labor amount of $3,500.62, in turn multiplied by facility wage index 0.9362 for an adjusted labor amount of $3,277.28

  The non-labor portion is 40% of the APC rate, or $2,333.74.

  The sum of the labor and non-labor portions is $5,611.02.

  The Medicare facility specific amount is $5,611.02 multiplied by 200% for a MAR of $11,222.05.

3. The total recommended reimbursement for the disputed services is $11,222.05. The insurance carrier paid $8,522.05 to the requester. A second payment was issued but the check information indicates payment was made to PA Surgical in Bedford, Texas not the requester (Crescent Medical Center). The requester is due an additional payment of $2,700.00.

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 established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that Indemnity Insurance Co of North America must remit to Crescent Medical Center $2,700.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		December 29, 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.