



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Surgery Specialty Hospitals of America S.E.

Respondent Name

Berkshire Hathaway Direct Insurance

MFDR Tracking Number

M4-26-0122-01

Carrier's Austin Representative

Box Number 06

DWC Date Received

September 11, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 17, 2024	Repair Rotator Cuff	\$4,719.04	\$4,719.04

Requester's Position

"The Carrier is required to reimburse the Provider \$13,482.97 pursuant to the Outpatient Fee Guideline. The Carrier made a partial payment of \$8,763.93. Therefore, the Carrier is required to reimburse the Provider an additional amount of \$4,719.04, plus all applicable interest."

Amount in Dispute: \$4,719.04

Respondent's Position

The Austin carrier representative for Berkshire Hathaway Direct Insurance is Stone Loughlin & Swanson LP. The representative was notified of this medical fee dispute on September 15, 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 §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.

[287 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.

[28 TAC §133.10](#) sets out guidelines to request separate implant reimbursement.

[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:

- 252 – An attachment/other documentation is required to adjudicate this claim/service.
- 253 – In order to review this charge please submit a copy of the certified invoice.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- U03 – The billed service was reviewed by UR and authorized.
- 253 – We have reviewed the all the reports. But there is no itemized statement page for the below service. Please provide itemized statement for payment.

Issues

1. Did the requester submit a request for separate implant reimbursement?
2. What is the rule applicable to reimbursement?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking payment of outpatient hospital charges rendered on September 17, 2024. The insurance carrier denied Revenue Code 278 stating an invoice was required.

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 23410 has status indicator J1, for procedures paid at a comprehensive rate. All the services covered on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5114. The OPPS Addendum A rate is \$6,816.33 multiplied by 60% for an unadjusted labor amount of \$4,089.80, in turn multiplied by facility wage index 0.9817 for an adjusted labor amount of \$4,014.96

The non-labor portion is 40% of the APC rate, or \$2,726.53

The sum of the labor and non-labor portions is \$6,741.49.

The Medicare facility specific amount is \$6,741.49 multiplied by 200% for a MAR of \$13,482.98.

3. The total recommended reimbursement for the disputed services is \$13,482.98. The insurance carrier paid \$8,763.93. The requestor is seeking additional reimbursement of \$4,719.04. This amount is 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 established that additional reimbursement of \$4,719.04 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 Berkshire Hathaway Direct Insurance Company must remit to Surgery Specialty Hospital of America, S.E. \$4,719.04 plus applicable accrued interest within 30 days of receiving this order in accordance with [28 TAC §134.130](#).

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

December 19, 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.