TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Legent Outpatient Surgery Center

Respondent Name
Hartford Ins Co of Illinois

MFDR Tracking Number
M4-26-0154-01

Insurance Carrier's Austin Representative
BOX 47 Burns Anderson Jury Brenner & Donovan

DWC Date Received
September 16, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
November 26, 2024	C1713	$0.00	$0.00
November 26, 2024	C1762	$1,967.20	$0.00
	Total	$1,967.20	$0.00

Requester's Position

"Attention claims Attached is a corrected claim were we are askign[sic] for seperate[sic] reimbursement for implants codes. Attached also are supporting Docuemnts[sic]."

Amount In Dispute: $1,967.20

Respondent's Position

"We identified on the initial submission, the bill recommended payment of $8,758.90 in error. The bill should have denied as the provider submitted the services on the incorrect billing form. The provider should be billing ASC services on a CMS-1500 form."

Response Submitted By: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code Section 413.031 and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section 133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section 134.402 sets out the ambulatory surgical center fee guideline.
3. 28 TAC Section 133.10 sets out the required billing forms/formats.

Adjustment Reasons

- 00663 – Reimbursement has been calculated based on state guidelines.
- P12-1 – 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.
- TX618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- TX350 – Bill has been identified as a request for reconsideration or appeal.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the insurance carrier's denial reason supported?

Findings

1. The requester seeks reimbursement in the amount of $1,967.20 for implant-related surgical services rendered on November 26, 2024, in an Ambulatory Surgical Center (ASC).

   The insurance carrier denied payment, asserting that the services were submitted on an incorrect billing form. Specifically, the carrier maintains that ASC services must be billed on a CMS-1500 claim form rather than a UB-04.

2. A review of the medical and billing documentation confirms that the disputed services were performed in an ASC and that the requester submitted the claim using a UB-04 form.

   Pursuant to 28 TAC Section 134.402(d), facility services covered under this rule must be coded, billed, and reported in accordance with Medicare payment policies in effect on the date the services were provided. The Medicare Claims Processing Manual, Chapter 14 (Ambulatory Surgical Centers), Section 10, provides that ASCs must submit claims using the

ASC X12 837 professional claim format or, in limited circumstances, Form CMS-1500 in order to receive ASC payment.

Because the requester billed the ambulatory surgical services on a UB-04, the claim submission does not comply with 28 TAC Section 134.402 or applicable Medicare billing requirements. Accordingly, reimbursement for the disputed services is not warranted.

Therefore, reimbursement of $0.00 is recommended for the services in dispute.

Conclusion

The outcome of this medical fee dispute is based on the evidence requester and the respondent presented at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that reimbursement is due.

Order

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

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 23, 2026 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section 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 800-252-7031, option three 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section 141.1(d).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.