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
Corpus Christi

Respondent Name
City of Corpus Christi

MFDR Tracking Number
M4-26-0237-01

Carrier's Austin Representative
Box Number 21

DWC Date Received
September 23, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 27, 2025	23430	$627.82	$627.80

Requester's Position

"We have been underpaid per the Texas work compensation fee schedule...We have only been paid $7,218.37. We are owed an additional $627.82, to be in compliance with the TX WC FS rules, regulations and administrative codes."

Amount in Dispute: $627.82

Respondent's Position

"The client will be sending in a response shortly."

Response submitted by: Thornton Biechlin Reynolds & Guerra LC

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

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.305 sets out general Medical Dispute Resolution guidelines.
3. 28 TAC §134.402 sets out the fee guidelines for ambulatory surgical centers.

Adjustment Reasons

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

- 193 – Original payment decision is being maintained. Upon review it was determined that the claim was processed properly.
- W3 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. What Rule applies to the reimbursement of the service in dispute?
2. Is the requester entitled to additional reimbursement for the disputed service?

Findings

1. This medical fee dispute involves facility charges for surgical services rendered in a licensed ambulatory surgical center. The requester, Legent Outpatient Surgery Corpus Christi, is requesting additional reimbursement for surgical procedure code 23430.

   DWC Rule 28 TAC §134.402 (d), which applies to the disputed service, 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 10.1.2 specifically Ambulatory Surgical Center Services on ASC list. Beginning with the implementation of the 2008 revised payment system, the labor related adjustments to the ASC payment rates are based on the Core-Based Statistical Area (CBSA) methodology. Payment rates for most services are geographically adjusted using the pre-reclassification wage index values that CMS uses to pay non-acute

providers. The adjustment for geographic wage variation will be made based on a 50 percent labor-related share.

DWC Rule 28 TAC §134.402 (f) states in pertinent part the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register.

Reimbursement shall be based on the fully implemented payment amount published in the Federal Register. Reimbursement for device intensive procedures shall be the sum of the ASC device portion and the ASC service portion multiplied by 235 percent.

2. The requester is seeking additional reimbursement in the amount of $627.82 for procedure code 23430 rendered on May 27, 2025, in a licensed ambulatory surgical center. On the disputed date of service, the requestor billed for one unit of procedure code 23430-RT along with another related surgical implant code. Per review of the submitted DWC060 Medical Fee Dispute Resolution (MFDR) Request form, procedure code 23430 is the only procedure code in dispute, therefore, only this procedure code will be reviewed and adjudicated. Separate reimbursement for implants was not requested on the medical bill.

   In accordance with 28 TAC §134.402, the MAR for the service in dispute is calculated as follows:

   Procedure Code 23430 has an ASC payment indicator of J8 which indicates a device intensive procedure paid at an adjusted rate.

   The following formula is used to calculate the MAR:

   Step 1 calculating the **device portion** of the procedure:

   Per 28 TAC §134.402 (b)(2), "ASC device portion" means the portion of the ASC payment rate that represents the cost of the implantable device and is calculated by applying the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS) device offset percentage to the OPPS payment rate. The device offset percentage information can be found in the CMS OPPS Addendum P.

   - The national reimbursement is found in Addendum B for National Hospital Outpatient Prospective Payment System (OPPS). The rate for procedure code 23430 on the applicable date of service = $7,143.73.
   - The device dependent APC offset percentage for National Hospital OPPS in Addendum P for code 23430 on the applicable date of service is 29.56%.
   - Multiply the above $7,143.73 x 29.56% = $2,111.687, the device portion of the procedure.

Step 2 calculating the **service portion** of the procedure:

Per 28 TAC §134.402 (b)(3), "ASC service portion" means the Medicare ASC payment rate less the device portion.

- Per Addendum AA, the Medicare ASC reimbursement rate for code 23430 for CY 2025 is $4,603.45.
- This number is divided by 2 = $2,301.725.
- This number multiplied by the CBSA for the Corpus Christi, Texas region of 0.9776 = $2,250.166.
- The sum of these two, $2,301.725 + $2,250.166, is the geographically adjusted Medicare (MC) ASC reimbursement $4,551.891.
- The service portion is found by subtracting the device portion $2,111.687 from the geographically adjusted MC ASC rate $4,551.891 = $2,440.204.
- Multiply the service portion by the DWC payment adjustment of 235% = $5,734.479, the final DWC service portion amount.

Step 3 calculating the **MAR**:

- The MAR is determined by adding the sum of the device portion $2,111.687 and the final DWC service portion $5,734.479 = $7,846.166.

DWC finds the MAR for the disputed CPT code 23430, rendered on May 27, 2025, is $7,846.17. The insurance carrier paid $7,218.37. Therefore, additional reimbursement in the amount of $627.80 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 in the amount of $627.80 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the service in dispute. It is ordered that the Respondent, City of Corpus Christi, must remit to the Requester, Legent Outpatient Surgery Corpus Christi, $627.80 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		January 8, 2026
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.