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

Joel H Hurt MD

Respondent Name

American Zurich Insurance Company

MFDR Tracking Number

M4-26-0240-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

September 24, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
April 8, 2025	20610-LT	$387.48	$39.29
	Total	$387.48	$39.29

Requester's Position

"See page 9 of this complaint which details why the left knee injection (20610-LT) should be paid and NOT considered bundled to the right shoulder surgery."

Amount In Dispute: $387.48

Respondent's Position

The Austin carrier representative for American Zurich Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on September 24, 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 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 guidelines for ambulatory surgical centers.

Adjustment Reasons

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 59 – Charges are adjusted based on Multiple surgery rules or concurrent anesthesia rules.
- 97 – Payment adjusted because 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.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the insurance carrier's denial supported?
3. What rule is applicable to reimbursement?
4. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking reimbursement of code 20610-LT for date of service April 8, 2025. This insurance carrier denied the claim line as being packaged. The amount in dispute is

$387.48.

2. The submitted documentation (Operative Report) indicates two procedures performed on the right shoulder and one procedure on the left knee. As the left knee injection was indicated for a different diagnosis and body part, the insurance carrier's denial for packaging of the procedure into the shoulder surgery is not supported. The service in dispute will be reviewed per applicable fee guideline.

3. 28 TAC Section 134.402(e)(f) states in pertinent parts,

   (e) Regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) 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 reimbursement for implantables.

   (f) The reimbursement calculation used for establishing the 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 published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the Federal Register, or its successor. The following minimal modifications apply:

   (1) Reimbursement for non-device intensive procedures shall be:

   (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent;

   Procedure Code 20610 has a payment indicator of P3. The following formula was used to calculate the MAR:

   - The Medicare ASC reimbursement for code 20610 for applicable date of service is $33.64. Review of ASC Addenda AA at www.cms.gov, found this code is subject to multiple procedure discounting.
   - The Medicare ASC reimbursement is divided by 2 = $16.82.
   - This number is multiplied by the CBSA wage index. The Medicare Claims Processing Manual, Chapter 14, Section 40.2 at www.cms.gov, states, for dates of service on or after January 1, 2008, the ASC payment rates are geographically wage adjusted based on the wage index for the CBSA. The wage index for CBSA 12420, Austin, Texas is 0.988 multiplied by the above = $16.62.

- Add these two together = $33.44.
- To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = $33.44 x 235% = $78.58 reduced by 50% is $39.29.

4. The MAR for code 20610 for date of service April 8, 2025 in the location of Austin, Texas based on the applicable multiple procedure discounting is $39.29. This amount is recommended.

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 established that reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that American Zurich Insurance Co must remit to Joel H Hurt MD $39.29 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 20, 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.