



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Legent Outpatient Surgery
Austin

Respondent Name

Old Republic Insurance Co

MFDR Tracking Number

M4-26-0243-01

Carrier's Austin Representative

Box Number 44

DWC Date Received

September 24, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 7, 2025	C1713	\$3460.35	\$0.00

Requester's Position

"We are asking for separate reimbursement for implants."

Amount in Dispute: \$3,460.35

Respondent's Position

"...the fee guidelines do not support any reimbursement as the provider's bill does not conform to the requirements of the Texas Fee Guidelines."

Response submitted by: White Espey PLLC

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 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §133.210](#) sets out the requirements of medical documentation.

Denial Reasons

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

- 4123 – Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
- 4915 – the charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is package or excluded from payment.
- 983 – Charge for this procedure exceeds Medicare ASC schedule allowance.
- 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. Is the respondent's position statement supported?
2. What rule is applicable to medical billing?

Findings

1. The respondent states in their position statement, "None of the separate billing for the implants submitted by the provider contain this certification language. DWC Rule 28 TAC 134.402 (g)(1)(B) states, A facility, or surgical implant provider with written agreement of the facility, may request separate reimbursement for an implantable.

(1) The facility or surgical implant provider requesting reimbursement for the implantable shall:

(A) bill for the implantable on the Medicare-specific billing form for ASCs;

(B) include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge," and shall be signed by an authorized representative of the facility or surgical implant

provider who has personal knowledge of the cost of the implantable and any rebates or discounts to which the facility or surgical implant provider may be entitled.

Review of the documents submitted with this request found on page 11 an invoice from Arthrex. The top of the invoice found the statement, "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge. Signed by (illegible) RN. The respondent's position is not supported. The applicable DWC rules and regulations will be considered during this review.

2. DWC Rule 28 TAC §133.210 (c)(5) states, In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation:

(5) for hospital services: an itemized statement of charges.

The information submitted with this request for MFDR did not contain an itemized statement in support of the nine units of code C1713 as required by applicable rule. The required supporting documentation was not submitted with this request for MFDR. No payment is recommended.

Conclusion

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

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

Order

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

Authorized Signature

_____	_____	December 4, 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 electrónico CompConnection@tdi.texas.gov.