TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Crescent Regional Hospital

Respondent Name
Amtrust Insurance Co

MFDR Tracking Number
M4-26-0391-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
October 8, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 29, 2025	Rev 0360 23410, 29823, 29824, 29826	$3619.06	$3,456.19
April 29, 2025	Rev 0278	$0.00	$0.00
April 29, 2025	All other	$0.00	$0.00
	Total	$3,619.06	$3,456.19

Requester's Position

"We did not request separate payment for implants. The expected MAR amount for CPT 23410, 29823, 29824, and 29826 was $13,903.41."

Amount in Dispute: $3619.06

Respondent's Position

"Please see the attached EOBs. The Carrier has paid a total of $10,284.35. This amount was inclusive of the entire surgical procedure, the APC rate plus the markup. In conclusion, Requestor is not owed any additional reimbursement for the surgical procedure."

Response submitted by: Downs Stanford PC

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.
- 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
- DWC Rule TAC §133.10 details how the requester seeks 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:

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 350 – Bill has been identified as a request for a request for reconsideration or appeal.
- 353 – This charge was reviewed according to the submitted invoice and documentation.
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 97 – 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.
- Q02 – No additional allowance recommended. The documentation has been evaluated and does not support an additional allowance.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- Re-evaluation: Upon further review, no additional allowance is recommended.
- Implant:Note:Line6-Provider billed for 3 units for implant as per review records

supporting only 2 units(please submit implant invoice for reconsideration).

Issues

1. Is the insurance carrier's denial supported?
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 April 29, 2025. The insurance carrier states on the explanation of benefits how implant reimbursement was calculated.

   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*.

   (1) 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 covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5114. The OPPS Addendum A rate is $7,143.73 multiplied by 60% for an unadjusted labor amount of $4,286.24, in turn multiplied by facility wage index 0.9362 for an adjusted labor amount of $4,012.78.

  The non-labor portion is 40% of the APC rate, or $2,857.49.

  The sum of the labor and non-labor portions is $6,870.27.

  The Medicare facility specific amount is $6,870.27 multiplied by 200% for a MAR of $13,740.54.

- Procedure code 29823 has status indicator J1 however the applicable Medicare payment policy only allows payment of the highest ranked J1 code. Review of Addenda J at www.cms.gov finds Code 29823 has a ranking of 1,833. Code 23410 has a ranking of 611. Code 23410 is the highest ranking J1 code and therefore is the only payable claim line.
- Procedure code 29824 has status indicator J1 the rank of code 29824 is 1,877. The rank of Code 23410 is 611. Code 23410 is the only payable J1 code.
- Procedure code 29826 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.

3. The total recommended reimbursement for the disputed services is $13,740.54. The insurance carrier paid $10,284.35. The amount due is $3,456.19. 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 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 Amtrust Insurance Company must remit to Crescent Regional Hospital $3,456.19 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 6, 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 electronico CompConnection@tdi.texas.gov.