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

General Information

Requester Name

North Central Baptist Medical Center

Respondent Name

Ace American Insurance Company

MFDR Tracking Number

M4-26-2201-01

Insurance Carrier's Austin Representative

BOX 15 Downs Stanford PC

DWC Date Received

April 6, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
July 15, 2025	0250	$310.00	See total due
July 15, 2025	0278	$54,331.76	See total due
July 15, 2025	0360	$66,329.65	See total due
July 15, 2025	0370	$15,118.00	See total due
July 15, 2025	0636	$3,743.06	See total due
July 15, 2025	0710	$11,685.00	See total due
N/A	WC Adjustments	($146,926.62)	See total due
	Total	$4,582.25	$339.65

Requester's Position

"The Hospital billed CORVELL-CORCARE, but the bill was underpaid and not paid/reimbursed appropriately. However, despite the Hospital's efforts and Request for Reconsiderations sent, CORVELL-CORCARE has not rendered proper payment."

Amount In Dispute: $4,582.25

Respondent's Position

"There was no indication in box 80 of the UB04 billing form that separate reimbursement was requested for implants. As such, reimbursement was made in accordance with Rule 134.403(f)(1)(A)… Both CPT codes 23552 and 29823 have OPSI codes of J1. Per CMS, 29823 is bundled into the payment for 23552… Finally, please note this employer, … , is not a participant in the Corvel Texas Healthcare Network. As such, any contract the HCP has with Corvel is not applicable."

Response Submitted By: Corvel

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 134.403 sets out the guidelines for outpatient hospital services.
3. 28 TAC Section 133.10 sets out the requirements for a complete medical bill.

Adjustment Reasons

The insurance carrier reduced payment for the disputed services with the following reasons:

1. 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
2. P14 – The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.
3. P12 – Workers' compensation jurisdictional fee schedule adjustment.
4. 234 – This procedure is not paid separately.
5. RN – Not paid under OPPS; services included in APC rate.
6. XP – Separate practitioner

Issues

1. What is DWC considering in this medical fee dispute?

2. What rules apply to the services in dispute?

3. Did the health care facility request separate reimbursement for surgical implants in accordance with applicable DWC Rules?

4. Is the insurance carrier's denial of separate reimbursement for disputed procedure code 64415-XP-LT supported?

5. What is the maximum allowable reimbursement (MAR) for the services in question?

6. Is the requester entitled to additional reimbursement?

Findings

1. This medical fee dispute resolution (MFDR) request involves reduced payment for outpatient facility charges for services rendered on July 15, 2025.

   A review of the submitted DWC Form-060 *Medical Fee Dispute Resolution Request* (DWC Form-060), finds that the requester populated the "Service Codes in Dispute" section of the form with revenue codes which correspond to the following services or procedure codes on the medical bill:

   - 0250 corresponds to pharmacy services
   - 0278 corresponds to implantable procedure codes C1713 and C1762
   - 0360 corresponds to surgery procedure codes 23552, 29823, and 64415
   - 0370 corresponds to timed anesthesia services
   - 0636 corresponds to medications represented by J leading procedure codes
   - 0710 corresponds to recovery room services

   The insurance carrier has previously reimbursed the requester in the total amount of $13,798.29 for the date of service in dispute. The requester, North Central Baptist Medical Center, is seeking additional reimbursement in the amount of $4,582.25.

   DWC will review the submitted documentation to determine if the requester is entitled to additional reimbursement in accordance with applicable DWC Statutes and Rules.

2. Because the services in dispute were rendered in an outpatient hospital facility, DWC finds that 28 TAC Section 134.403 applies to the disputed services.

   DWC Rule 28 TAC Section 134.403, which sets out the fee guidelines for outpatient hospital services, states in pertinent part, "(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall

apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section…"

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 Section 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*. The following minimal modifications shall be applied.
>
> "(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
>
> (A) 200 percent; unless
>
> (B) a facility or surgical implant **provider requests separate reimbursement in accordance with subsection (g) of this section,** in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.
>
> (g) Implantables, **when billed separately by the facility** or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-ons per admission."

28 TAC Section 133.10, which sets out required medical billing forms/formats, applies to this MFDR review stating in pertinent part, "(f) All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form…

> (2) **The following** data content or data elements **are required for a complete institutional medical bill** related to Texas workers' compensation health care: …
>
> (QQ) **remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested."**

3. A review of the submitted medical bill finds that field 80 of the UB-04 institutional medical claim form was not populated with a request for separate reimbursement of surgical implant products or devices.

DWC finds that the requester did not request separate reimbursement for surgical implants in accordance with DWC Rules 28 TAC Section 134.403 and 28 TAC Section 133.10.

Therefore, the requester is not entitled to separate reimbursement for disputed implant procedure codes C1713 and C1762 billed under revenue code 0278. The appropriate reimbursement for the outpatient hospital services rendered on July 15, 2025, shall be 200 percent of the Medicare facility specific reimbursement amount, in accordance with 28 TAC Section 134.403.

4. A review of the submitted explanation of benefits (EOB) finds that the insurance carrier denied separate reimbursement for procedure code 64415-XP-LT stating that the charge for CPT code 64415-XP-LT is included (packaged) in another charge or service rendered and billed on the same date.

   Procedure code 64415 is described as "a single-injection or bolus brachial plexus nerve block (interscalene, supraclavicular, or infraclavicular approach) using an anesthetic agent and/or steroid, with imaging guidance included in the code when performed."

   Medicare Claims Processing Manual, Chapter 4, 10.4 – Packaging, states in pertinent part, "Under the OPPS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPPS. No separate payment is made for packaged services, because the cost of these items and services is included in the APC payment for the service of which they are an integral part. For example, routine supplies, anesthesia, recovery room use, and most drugs are considered to be an integral part of a surgical procedure so payment for these items is packaged into the APC payment for the surgical procedure… C. Packaging Types Under the OPPS: … 6. J1 services are assigned to comprehensive APCs. Payment for all adjunctive services reported on the same claim as a J1 service is packaged into payment for the primary J1 service."

   A review of the submitted medical bill and the OPPS addendum B for CY 2025, finds that two procedure codes billed on the disputed date of service are assigned status indicator J1. OPPS status indicator J1 indicates that "all covered part B services on the claim are packaged with the primary 'J1' service for the claim, except services with OPPS status indictor of 'F', 'G', 'H', 'L', and 'U'; ambulance services, diagnostic and screen mammography, rehabilitation therapy services, services assigned to a new technology services, services assigned to a new technology APC, self-administered drugs, all preventive services, and certain part B inpatient services."

   According to OPPS addendum B for CY 2025, procedure code 64415 has a status indicator of T and does not fall under the description of the exceptions to packaged J1 APC services.

DWC finds that the insurance carrier's reason for denial of procedure code 64415-XP-LT rendered on July 15, 2025, is supported. Consequently, separate reimbursement for this disputed code is not recommended.

5. According to the submitted EOB, the insurance carrier has previously reimbursed the disputed services in the total amount of $13,798.29. The requester is seeking additional reimbursement in the amount of $4,582.25 for outpatient hospital services rendered on July 15, 2025. DWC calculates the total MAR for the disputed date of service as follows.

   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 in accordance with the applicable fee guidelines referenced above is shown below.

   - Billed procedure codes 23552 and 29823 both have a status indicator of J1, for outpatient comprehensive packaging. DWC finds that of these two procedure codes billed on the disputed claim, both having status indicator J1, procedure code 23552 is the only payable code, as it is ranked as primary.
   - **Procedure code 23552** is assigned APC 5114. The OPPS Addendum A rate is $7,143.73 multiplied by 60% for an unadjusted labor amount of $4,286.238, in turn multiplied by facility wage index 0.8957 for an adjusted labor amount of $3,839.183.
   - The non-labor portion is 40% of the APC rate, or $2,857.492.
   - The sum of the adjusted labor amount and the non-labor portion is $6,696.675.
   - Therefore, the Medicare facility specific amount is $6,696.675.
   - **Separate implant reimbursement was not requested** per the submitted medical bill. Therefore, the Medicare facility specific amount is multiplied by **200%** for a **MAR of $13,393.35** for procedure code **23552**.

   - Procedure code J0666 has a status indicator of K1, indicating this service receives separate reimbursement and is paid under OPPS.
   - **Procedure code J0666** is assigned APC 0763. The OPPS Addendum A rate is $1.493 multiplied by 60% for an unadjusted labor amount of $0.8958, in turn multiplied by facility wage index 0.8957 for an adjusted labor amount of $0.8024.
   - The non-labor portion is 40% of the APC rate, or $0.5972.
   - The sum of the adjusted labor amount and the non-labor portion is $1.3996.
   - Therefore, the Medicare facility specific amount is $1.3996.

- The Medicare facility specific amount is multiplied by **200%** for a MAR of $2.7992 per unit.
- Per the submitted medical bill, the requester billed for 266 units. The medical reports submitted support administration of 266 units of the medication, bupivacaine liposome, represented by procedure code J0666.
- The **MAR** for **266 units** of procedure code **J0666 is $744.59** rendered on July 15, 2025.

- Procedure code J1596 has a status indicator of K, indicating this service receives separate reimbursement and is paid under OPPS.
- Per review of the submitted medical bill, the requester billed for 10 units of J1596. However, a review of the submitted medical report finds that administration of 10 units of the medication glycopyrrolate, represented by procedure code J1596, is not supported by the medical documentation.
- Additional reimbursement for procedure code J1596 is not recommended.

- All other J leading procedure codes, under revenue code 0636 on the submitted bill, have an OPPS status indicator of N, indicating they are all packaged into the payment for the primary J1 procedure code 23552.

- DWC finds that services billed under revenue codes 0250, 0370 and 0710 are considered to be an integral part of the primary J1 surgical procedure code 23552 and are packaged into the payment for the primary J1 code 23552.

DWC finds that the total MAR for the disputed outpatient hospital services rendered on July 15, 2025, is $14,137.94.

6. The requester is seeking additional reimbursement in the amount of $4,582.25 for outpatient hospital services rendered on July 15, 2025.

   DWC finds that the total MAR for the disputed date of service is $14,137.94. The insurance carrier has previously paid a total of $13,798.29 for the services in dispute, therefore, additional reimbursement in the amount of $339.65 for the disputed services rendered on July 15, 2025, is recommended.

   DWC finds that the requester is entitled to additional reimbursement in the amount of $339.65.

Conclusion

The outcome of this medical fee dispute is based on the evidence the 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 additional reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that Ace American Insurance Company must remit to North Central Baptist Medical Center $339.65 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	June 3, 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.