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

Requestor Name
Texas Health Allen

Respondent Name
Argonaut Insurance Co

MFDR Tracking Number
M4-23-3147-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
July 26, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 9, 2023	0360	$7,530.82	$5,064.54

Requestor's Position

"Attached is a copy on and EOB, UB04, and an itemized statement and medical records. The claim referenced below was billed with CPT Code 49650, and the Medicare reimbursement is $17,659.90 as referenced in the copy of the Medicare Pricer included in this request. We are in receipt of a payment of $10,129.08, however this claim was underpaid by $10,129.08 and the outpatient work comp multiplier is 200% without separate implant reimbursement per rule 134.403, see below), and the total work comp fee schedule allowance is $17,659.90, and finally, deducting the payment $10,129.08, **leaves an unpaid balance due of $7,530.82**."

Amount in Dispute: $7,530.82

Respondent's Position

"The Austin carrier representative for Argonaut Insurance Co is Downs Stanford PC. The representative was notified of this medical fee dispute on August 22, 2023.

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 §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 §134.403 sets out the fee guidelines for outpatient hospital services.

Denial Reasons

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

- 192 – Non standard adjustment code from paper remittance.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 252 – An attachment /other documentation is required to adjudicate this claim/service
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 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 is applicable to reimbursement?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment for outpatient hospital services rendered in January of 2023. The DWC 60 submitted with this dispute listed all billed revenue codes but only Revenue Code 360 listed an amount in dispute of $7530.82. This line is the only claim line in dispute and will be reviewed per applicable fee guideline,

Their position statement includes, "…the Medicare reimbursement is $17,659,90 as referenced in the copy of the Medicare Pricer included in this request. Hospital OPPS services do not have a Medicare Pricer. The correct fee calculations per Rule 134.403 are shown below.

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) states in pertinent part, regardless of billed amount, when no specific fee schedule or contract reimbursement shall be 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*.

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 is shown below.

Procedure code 49650-50 has a status indicator of J1. HCPCS code 22903 also has a status indicator of J1. Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:

- major OPPS procedure codes (status indicators P, S, T, V)
- lower ranked comprehensive procedure codes (status indicator J1) Payment is made for the highest ranking code.

HCPCS Code 49650-50 has a ranking of 1,031. HCPCS Code 22903 has a status indicator of J1 and a ranking of 2,459.00, The highest ranking code is 49650-50.

- Addendum A allowable $5212.15 x 60% = $3,217.29 x wage index 0.9528 = $2,979.68
- $5,212.15 x 40% = $2,084.86
- $2,979.68 +$2,084.68 = $5064.54 x 200% = $10,129.08

This code was submitted with the 50 – modifier. Medicare Claims Processing Manual 20.6.2 - Use of Modifiers -50, -LT, and -RT (Rev. 11937; Issued: 03-31-23; Effective: 04-

01-23; Implementation: 04-03-23) states, 50: Bilateral Procedure - Modifier 50 is used to report bilateral procedures that are performed on both sides of the body at the same operative session. Do not report modifiers RT and LT when modifier 50 applies. Do not submit two line items to report a bilateral procedure using modifier 50. Report one line with modifier 50 using one unit of service.

Modifier 50 applies to any bilateral procedure performed on both sides at the same operative session. The bilateral modifier 50 is restricted to operative sessions only

The MAR of Code 49650-50 is $1029.08 / 50% = $5064.64.
$10129.08 + 5064.64 = $15193.62

The total recommended reimbursement for the disputed services is $15,193.62. The insurance carrier paid $10,129.08. The amount due is $5,064.54. 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 requestor is entitled to additional reimbursement for the disputed services. It is ordered that Argonaut Insurance Co must remit to Texas Health Allen $5,064.54 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		October 13, 2023
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.