



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Texas Health Center for Diagnostic

Respondent Name

Dallas Area Rapid Transit

MFDR Tracking Number

M4-24-1222-01

Carrier's Austin Representative

Box Number 53

DWC Date Received

January 30, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 5, 2023	0250	Left blank	\$0.00
April 5, 2023	0270	Left blank	\$0.00
April 5, 2023	0272	Left blank	\$0.00
April 5, 2023	0278	Left blank	\$0.00
April 5, 2023	0360	Left blank	\$3,064.54
April 5, 2023	0370	Left blank	\$0.00
April 5, 2023	636	Left blank	\$0.00
April 5, 2023	636	Left blank	\$0.00
April 5, 2023	636	Left blank	\$0.00
April 5, 2023	636	Left blank	\$0.00
April 5, 2023	636	Left blank	\$0.00
April 5, 2023	636	Left blank	\$0.00
April 5, 2023	636	Left blank	\$0.00
April 5, 2023	636	Left blank	\$0.00
April 5, 2023	636	Left blank	\$0.00
April 5, 2023	636	Left blank	\$0.00
April 5, 2023	636	Left blank	\$0.00
April 5, 2023	636	Left blank	\$0.00
April 5, 2023	636	Left blank	\$0.00
April 5, 2023	636	Left blank	\$0.00
April 5, 2023	710	Left blank	\$0.00
	Total	\$7,530.82	\$3,064.54

Requestor's Position

"Attached is a copy of an EOB, UB04, an itemized statement, medical records. We are submitting this claim for reconsideration of medical services charged on the UB04. ...We have reviewed the attached claim and EOB and appeal. Partial payment made in amount of \$10,129.08 with a balance of \$7,530.82."

Amount in Dispute: \$7,530.82

Respondent's Position

"The provider is not owed any additional payment. Below is how the payment was figured. We did allow at 200% but we have Medicare Allowance different information.

Response submitted by: Hoffman Kelley Lopez LLP

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:

- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Bill is a reconsideration or appeal.
- 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 packaged or excluded from payment.

- 802 – Charge for this procedure exceeds the OPPS 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. 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.
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.
 - Addendum A allowable $\$5212.15 \times 60\% = \$3,217.29 \times \text{wage index } 0.9528 = \$2,979.68$

- $\$5,212.15 \times 40\% = \$2,084.86$
- $\$2,979.68 + \$2,084.68 = \$5064.54 \times 200\% = \$10,129.08$

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. Review of the submitted operative report supports a bilateral procedure.

- The MAR of Code 49650-50 is $\$10,129.08 / 50\% = \5064.64 .
- $\$10129.08 + 5064.64 = \$15,193.62$

The total recommended reimbursement for the disputed services is \$15,193.62. The insurance carrier paid \$12,129.08. The amount due is \$3,064.54. 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 Dallas Area Rapid Transit must remit to Texas Health Center for Diagnostic \$3,064.54 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

February 29, 2024

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.