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

General Information

Requestor Name
Dallas Medical Center

Respondent Name
Texas Mutual Insurance C0

MFDR Tracking Number
M4-25-1753-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
April 2, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 9, 2024	Lumbar Medical Branch Blocks	$19.082.10	$2,531.58
	Total	$19,082.10	$2,531.58

Requestor's Position

"Internal Bill #TX3518980910 was denied for timely filing. 5/9/24 – Patient was seen at our facility. 6/19/24 (41 days post service) – Claim was faxed to 800-359-0650. 7/25/24 (77 days post service)- I called and was told this claim needed to be faxed to 512-224-3889 for processing which I did."

Amount in Dispute: $19,082.10

Respondent's Position

''Texas Mutual has reviewed the DWC-60 submitted by DALLAS MEDICAL CENTER. Texas Mutual on 9/10/2024 received the bill from Dallas Medical Center. ...Our position is that no payment is due."

Response submitted by: Texas Mutual

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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §102.4 details the general rules for Non-Division Communication.
3. 28 TAC §134.403 sets out the rules and fee guidelines for outpatient hospital services.

Denial Reasons

- CAC-29 – The time limit for filing has expired.
- 731 – Per 133.20(B) provider shall not submit a medical bill later than the 95th day after the date the service

Issues

1. Did the requestor support timely submission of the medical bill?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement outpatient hospital services rendered in May of 2024. The insurance carrier denied the medical bill stating claim was not filed timely.

   DWC Rule 28 TAC §102.4 (h) Unless the great weight of evidence indicates otherwise, written communications will be deemed to have been sent on:

   (1) the date received if sent by fax, personal delivery, or electronic transmission; or

   (2) the date postmarked if sent by mail through United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent must be the next previous day that is not a Sunday or legal holiday.

   Review of the information submitted with this request for MFDR included a fax confirmation dated July 25, 2024. The fax number of this submission was 512-224-3889. This number is on file as the fax number of the insurance carrier (Texas Mutual). The date of July 25, 2024 is within 95 days of the date of service (May 9, 2024). The insurance carrier's denial is not supported. The services in dispute will be reviewed per applicable fee guidelines.

2. The requestor is seeking payment of outpatient hospital services rendered on May 9, 2024. 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 exits 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*.

   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. Review of the submitted medical bill found a request for implants is not applicable.

   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 65593 -50 has a status indicator of "T" and is assigned APC 5443.

     - Addendum A allowable $868.45 x 60% = $521.07 x wage index 0.9528 = $496.48

     - $868.45 x 40% = $347.38

     - $496.48 + $347.38 = $843.86 x 200% = $1,687.72

     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: 04-4 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.

Based on the above, the bilateral procedure is paid at 50% of allowable. $1,687.72 x 50% = $843.86. The total facility specific amount is $1,687.72 + $843.86 for a total of $2,531.58

- Procedure code 64494 -LT has a status indicator of N and is packaged into the primary procedure.
- Procedure code 64494 -RT has a status indicator of N and is packaged into the primary procedure.

3. The total recommended reimbursement for the disputed services is $2,531.58. 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 Texas Mutual must remit to Dallas Medical Center $2,531.58 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 28, 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.