



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Baylor Surgical Hospital at Trophy Club

Respondent Name

Starr Specialty Insurance Co

MFDR Tracking Number

M4-25-2570-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

June 16, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 27, 2025	49507	\$3,155.58	\$3,155.58

Requester's Position

The requester submitted a document titled "Reconsideration" dated May 30, 2025 that states, "Per EOB received CPT code 49507 was not paid correctly per TX work comp guidelines."

Amount in Dispute: \$3,155.58

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determined if additional monies are owed."

Submitted by: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §133.305](#) sets out the procedures for resolving medical disputes.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §134.403](#) sets out the fee guidelines for outpatient hospital services.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking additional payment for outpatient hospital services rendered in January of 2025. The insurance carrier adjusted the billed amount based on packaging and workers' compensation fee schedule. 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 are shown below.

- Procedure code 49507-50 has a status indicator of J1.
 - Addendum A allowable $\$3,529.06 \times 60\% = \$2,117.44 \times$ wage index $0.9362 = \$1,982.35$
 - $\$3,529.06 \times 40\% = \$1,411.62$
 - $\$1,982.35 + \$1,411.62 = \$3,393.97 \times 200\% = \$6,787.94$

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) at <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf> 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. ...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 bilateral procedure.

- The MAR of Code 49507-50 is $\$6,787.94 / 50\% = \$3,393.97$
- $\$6,787.94 + 3,393.97 = \$10,181.91$

The total recommended reimbursement for the disputed services is \$10,181.91. The insurance carrier paid \$4,454.56. The remaining balance is \$5,727.35. The amount requested is \$3,155.58. 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 requester is entitled to additional reimbursement for the disputed services. It is ordered that Starr Specialty Insurance Co must remit to Baylor Surgical Hospital at Trophy Club \$3,155.58 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature

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 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 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 tres o correo electrónico CompConnection@tdi.texas.gov.