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

General Information

Requestor Name
Scenic Mountain Medical Center

Respondent Name
AIU Insurance Co

MFDR Tracking Number
M4-22-0226-01

Carrier's Austin Representative
Box Numb19

DWC Date Received
October 5, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 24, 2020	Rev Codes & 450	$65.88	$65.88
	Total	$65.88	$65.88

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code.

Amount in Dispute: $65.88

Respondent's Position

It is the carrier's position that the provider is not entitled to any additional reimbursement.

Response Submitted by: Flahive, Ogden & Latson

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 [description].

Denial Reasons

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

- P12 – Workers' Compensation State Fee Schedule Adj

Issues

1. Was the TC modifier submitted on the medical claim?

2. What rule applies for determining reimbursement for the disputed services?

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement of emergency room services rendered in December of 2020. The insurance carrier reduced the payment amount based on the workers' compensation state fee schedule. Review of the submitted medical bill found for code 70486 the health care provider did not append the "TC" modifier but when the carrier processed the claim it was processed with the "TC" modifier. The code 70486 will be reviewed as submitted on the medical bill contained within the documents submitted to MFDR.

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).

   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 70486 has status indicator Q3 and is assigned APC 5522. The OPPS Addendum A rate is $112.08. This is multiplied by 60% for an unadjusted labor amount of $67.25, in turn multiplied by facility wage index 0.9788 for an adjusted labor amount of $65.82.

  The non-labor portion is 40% of the APC rate, or $44.83.

  The sum of the labor and non-labor portions is $110.65.

  The Medicare facility specific amount is $110.65 multiplied by 200% for a MAR of $221.30.

- Procedure code 99284 has status indicator J2 if the comprehensive packaging criteria is met of 8 or more hours observation billed. The criteria is not met . This code is assigned APC 5024 with a status indicator of V.

  The OPPS Addendum A rate is $351.79. This is multiplied by 60% for an unadjusted labor amount of $211.07, in turn multiplied by facility wage index 0.9788 for an adjusted labor amount of $206.60.

  The non-labor portion is 40% of the APC rate, or $140.72.

  The sum of the labor and non-labor portions is $347.32.

  The Medicare facility specific amount is $347.32 multiplied by 200% for a MAR of $694.64.

3. The total recommended reimbursement for the disputed services is $915.94. The insurance carrier paid $821.53. The requestor is seeking additional reimbursement of $65.88. 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 of $65.88 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 AIU Insurance must remit to Scenic Mountain Medical Center $65.88 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 5, 2021
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.