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
Hunt Regional Medical Center

Respondent Name
AIU Insurance

MFDR Tracking Number
M4-22-0398-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 26, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 28, 2021	REV 250 - Pharmacy	$180,.40	$0.00
June 28, 2021	99285-ER	$1754.00	$1022.62
	Total	$1,934.00	$1022.62

Requestor's Position

Hunt Regional Medical Center submitted to Gallagher Bassett a First Report of Injury claim per Texas Division Worker's Compensation administrative rule 124.1a3. ...Per administrative rule 124.1a3, Gallagher Bassett is to comply with Hunt Regional's request to acknowledge medical documentation and bill charges that substantiate an injury occurred on (redacted). This did not happen.

Amount in Dispute: $1,934.00

Respondent's Position

The Austin carrier representative for AIU Insurance Co is Flahive, Ogden and Latson. The representative was notified of this medical fee dispute on December 1, 2021.

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

Neither party submitted an explanation of benefits that supports the adjudication of the disputed service.

Issues

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

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of outpatient hospital services rendered on June 28, 2021. They state in their position statement, "Hunt Regional Medical Center submitted to Gallagher Bassett a First Report of Injury claim per Texas Division Worker's Compensation administrative rule 124.1a3."

   The respondent did not submit a position statement in dispute of these charges. The services provided will be reviewed per applicable fee guidelines.

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 (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 99285 is assigned APC 5025. The OPPS Addendum A rate is $522.12.

  This is multiplied by 60% for an unadjusted labor amount of $313.27, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $302.46.

  The non-labor portion is 40% of the APC rate, or $208.85.

  The sum of the labor and non-labor portions is $511.31.

  The Medicare facility specific amount is $511.31. This is multiplied by 200% for a MAR of $1,022.62.

3. The total recommended reimbursement for the disputed services is $1,022.62. The insurance carrier paid $0.00. The amount due is $1,022.62. 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 $1,022.62 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 Hunt Regional Medical Center $1,022.62 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		January 10, 2022
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.