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

General Information

Requestor Name
Hunt Regional Medical Center

Respondent Name
AIU Insurance Co

MFDR Tracking Number
M4-22-0777-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
December 27, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 10, 2021	Pharmacy 5 units	$0.00	$0.00
February 11, 2021	Pharmacy 4 units	$0.00	$0.00
February 11, 2021	IV therapy 2 units	$0.00	$0.00
February 11, 2021	36415-1 unit	$0.00	$0.00
February 11, 2021	80053 - 1 unit	$0.00	$0.00
February 11, 2021	81003 - 1 unit	$0.00	$0.00
February 11, 2021	85025 - 1 unit	$0.00	$0.00
February 11, 2021	87426 - 1 unit	$0.00	$0.00
February 11, 2021	C9803 CS - 1 unit	$0.00	$0.00
February 10, 2021	73600 LT	$0.00	$0.00
February 11, 2021	73590 LT	$0.00	$0.00
February 11, 2021	73610 LT	$0.00	$0.00
February 11, 2021	97530 GP	$0.00	$0.00
February 11, 2021	97162 GP	$0.00	$0.00
February 11, 2021	27818 25	$2719.20	$0.00
February 11, 2021	51702	$0.00	$0.00
February 11, 2021	96374 XU	$547.00	$0.00
February 11, 2021	96375 XU	$118.00	$0.00
February 11, 2021	99285 25	$1670.00	$0.00
February 11, 2021	99218	$0.00	$0.00

		Total	5054.20	$0.00

Requestor's Position

Hunt Regional Medical Center submitted a corrected UB on 7/22/2021 and per the corrections Gallagher Bassett upheld their original payment decision and allowed payment for $2,719.20. Gallagher Bassett did not allow separate payents for codes 99285-25, 96374-XU, 96375-XU wh3en billed with 27818-25, Based on APC assignment and modifiers added each procedure is identified as distinct and separate procedures from procedure 27818-28. Therefore, 99285-25, 96374-XU and 96375-XU are payable separately.

Amount in Dispute: $xx

Respondent's Position

The carrier has reviewed it's position and stands by it's prior reimbursements. 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 the payment for the disputed services with the following claim adjustment codes:

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- B20 – Payment adjusted because procedure/service was partially furnished by another provider
- P12 – Workers' Compensaion Jurisdictional fee schedule adjustment
- 4097 – Paid per fee schedule: Charge adjusted because statue dictates allowance is greater than providers charge

- 96 – Non-covered charge(s)

Issues

1. Is the requestor's position supported by medical documentation?

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

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor states in their position statement, "Based on APC assignment and modifiers added each procedure is identified as distinct and separate procedures from 27818-25.

   Modifier "25" A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported

   Modifier "XU" Unusual nonoverlapping service, the use of a service that is distinct because it does not overlap usual components of the main service

   The documentation submitted with the request for MFDR does not support disputed services were above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The requestor's position is not supported. The services in dispute 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 27818 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5112.

  The OPPS Addendum A rate is $1,392.35 multiplied by 60% for an unadjusted labor amount of $835.41, in turn multiplied by facility wage index 0.9608 for an adjusted labor amount of $802.66.

  The non-labor portion is 40% of the APC rate, or $556.94.

  The sum of the labor and non-labor portions is $1,359.60.

  The Medicare facility specific amount is $1,359.60 multiplied by 200% for a MAR of $2,719.20.

- Procedure code 96374 XU is packaged into the primary J1 procedure shown above. Submitted documentation does not support separate and distinct service.

- Procedure code 96375 XU is packaged into the primary J1 procedure shown above. Submitted documentation does not support separate and distinct service.

- Procedure code 99285 25 is packaged into the primary J1 procedure shown above. Submitted documentation does not support separate and distinct service..

3. The total recommended reimbursement for the disputed services is $2,719.20. The insurance carrier paid $2,719.20. Additional payment is not 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 3, 2022 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.