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
TASB

MFDR Tracking Number
M4-22-0779-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
December 27, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 29, 2021	96374-XU	$547.00	$397.41
March 29, 2021	96375-XU	$472.00	$0.00
	Total	$1,765.00	$397.41

Requestor's Position

Please review all documentation provided to resolve Humt Regional Medical Center's payment dispute and to determine if procedures 99285-25, 96374-XU and 9375-XU are payable separately as stated above.

Amount in Dispute: $1,765.00

Respondent's Position

Based upon clarifying documentation an allowance has been recommended for date of service 03/29/2021 in the amount of $1,019.00

Response submitted by: TASB Risk Fund

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

The insurance carrier [reduced or denied] 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
- 217 – The value of this procedure is included in the value of another procedure performed on this date
- 351 – No additional reimbursement allowed after review of appeal/reconsideration
- 97 – The benefir for this service is included din the payment/allowance for another service/procedure that has already been adjudicated
- W3 – In accordance with TDI-DWC Rule 134.804. This bill has been identified as a request for reconsideration or appeal

Issues

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

2. Is the requester entitled to additional reimbursement?

Findings

1. 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 96374 has status indicator S, for procedures not subject to reduction. This code is assigned APC 5693. The OPPS Addendum A rate is $203.50 multiplied by 60% for an unadjusted labor amount of $122.10, in turn multiplied by facility wage index 0.9608 for an adjusted labor amount of $117.31.

  The non-labor portion is 40% of the APC rate, or $81.40.

  The sum of the labor and non-labor portions is $198.71.

  The Medicare facility specific amount is $198.71 multiplied by 200% for a MAR of $397.42.

- Procedure code 96375 - Therapeutic, Prophylactic, and Diagnostic Injections and Infusions. The Medicare policy specific to the disputed charge is found at www.cms.gov National Correct Coding Initiative Policy Manual For Medicare Service, Chapter 11 and states, "If the sole purpose of fluid administration (e.g., saline, D5W, etc.) is to maintain patency of an access device, the infusion is neither diagnostic nor therapeutic and shall not be reported separately. Similarly, the fluid used to administer drug(s)/substance(s) is incidental hydration and shall not be reported separately."

  Review of the submitted medical record indicates the administration of fluid was to maintain patency. Additional reimbursement is not recommended.

- Procedure code 99283 has status indicator J2 when rendered with 8 or more hours observation. This criteria was not met. This code is assigned APC 5023 with a status indicator of V. The OPPS Addendum A rate is $231.60 multiplied by 60% for an unadjusted labor amount of $138.96, in turn multiplied by facility wage index 0.9608 for an adjusted labor amount of $133.51.

  The non-labor portion is 40% of the APC rate, or $92.64.

  The sum of the labor and non-labor portions is $226.15.

  The Medicare facility specific amount is $226.15 multiplied by 200% for a MAR of $452.30.

2. The total recommended reimbursement for the disputed services is $849.72. The insurance carrier paid $452.31. The amount due is $397.41. 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 $397.41 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 TASB must remit to Hunt Regional Medical Center $397.41 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		March 30, 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.