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 Ctr

Respondent Name
AIU Insurance Co

MFDR Tracking Number
M4-22-1513-01

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
January 22, 2021	REV 250-Pharmacy	$1.70	$0.00
January 22, 2021	72070-Radiology	$351.00	$0.00
January 22, 2021	72100-Radiology	$360.00	$0.00
January 22, 2021	73140-Radiology	$257.00	$0.00
January 22, 2021	73610-Radiology	$296.00	$0.00
January 22, 2021	73630-Radiology	$296.00	$0.00
January 22, 2021	99283-ER	$710.00	$453.62
	Total	$2,271.70	$453.62

Requestor's Position

"Hunt Regional Medical Center submitted to Gallagher Bassett three First Report of Injury claims to Gallagher Bassett per Texas Division Worker's Compensation administrative rule 124.1a3. The request to review the First Report of Injury were submitted 3/31/2021, 5/18/2021, and 6/22/2021. Per administrative rule 124.1a3. Gallagher Bassett is to comply with Hunt Regional's request to acknowledge medical documentation and bill charges that substantiage an injury occurred on 1/15/2021. This did not happen. Therefore, Hunt Regioanl Medical Center is filing request to dispute the action to not comply."

Amount in Dispute: $2,271.70

Respondent's Position

"The provider filed a DWC-60 seeking medical fee dispute resolution for a date of service in January 22, 2021. The carrier has reevaluated it's position and is recommending reimbursement of $452.30 plus interest in the amount of $17.15. The carrier filed a PLN-11 on November 30, 2021 that disputed all conditions other than (redacted). All other conditions have been disputed."

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 outpatient hospital services.

Denial Reasons

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

- 00094 – Resolution manager denial
- 5721 – To avoid duplicate bill denial for all reconsideration/adjustment/additional payment requests submit a copy of this EOB or clear notation

Issues

1. Is the respondent's position supported?

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

3. Is the requester entitled to additional reimbursement?

Findings

1. The respondnet states in pertinent part in their position that a payment has been recommended with interest after the carrier re-evaluated the disputed charges. Review of the submitted documentation found insufficient evidence to support a payment of any kind was

made for the date of service in dispute. The medical bill charges will be reviewed per applicable fee guidelines shown below.

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 72070 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is packaged into code 99283.

- Procedure code 72100 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is packaged into code 99283.

- Procedure code 73140 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is packaged into code 99283.

- Procedure code 73610 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is packaged into code 99283.

- Procedure code 73630 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is packaged into code 99283.

- Procedure code 99283 has status indicator J2 when billed in combination with eight hours of more of observatation. As the criteria of comprehensive obseration was not met, the Status Indicator is V.

  This code is assigned APC 5023 with the OPPS Addendum A rate is $231.60.

This is multiplied by 60% for an unadjusted labor amount of $138.96, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $134.17.

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

The sum of the labor and non-labor portions is $226.81.

The Medicare facility specific amount is $226.81 multiplied by 200% for a MAR of $453.62.

3. The total recommended reimbursement for the disputed services is $453.62. The insurance carrier paid $0.00. The amount due is $453.62. 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 $453.62 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 Respondent must remit to Requestor $453.62 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 10, 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.