



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Hunt Regional Medical Center

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-22-0376-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

October 26, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 10, 2021	20680	\$1,725.00	\$272.97
February 10, 2021	27808	\$3,894.13	\$0.00
February 10, 2021	99218	\$8,061.98	\$0.00
Total		\$13,681.11	\$272.97

Requestor's Position

Hunt Regional Medical Center is disputing Texas Mutual's denial for (claimant) treatment for procedure 20680... Procedure 20680 is medically necessary to perform the primary surgery procedure 27808... Please note that code 20680 is not identified as a separate procedure and codes 27808 and 20680 should both be paid per OPPS-APC composite rule. ...Please review all documentation provided to resolve Hunt Regional Medical Center's dispute for the non-payment for codes 20680 and 99218.

Amount in Dispute: \$13,681.11 (The requestor did not complete the DWC60 to indicate the amount in dispute. However, the requestor asked for the codes shown above to be considered for medical fee dispute in their position statement. The total of these charges is shown here.)

Respondent's Position

Texas Mutual issued payment per OPPTS/APC Fee Guidelines and in accordance with Rule 134.403. No further payment is due.

Response Submitted by: Texas Mutual

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:

- P12 – Workers' Compensation jurisdictional fee schedule adjustment
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 356 – This outpatient allowance was based on the Medicare's methodology (Part B) plus the Texas markup
- 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
- 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure

Issues

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

Findings

1. The requestor is seeking additional reimbursement of outpatient hospital services rendered in February 2021. 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 27808 has a status indicator of T and an APC assignment of 5111. The Medicare Addendum A allowable is \$206.19. This is the only payable T code and therefore not subject to 50% reduction.

The 60% labor amount is \$123.71 multiplied by facility wage index of 0.9655 results in adjusted labor amount of \$119.44.

The 40% non-labor charge is \$82.48. The combined amount is \$201.92.

The total Medicare Adjusted APC payment is \$201.92 multiplied by 200% for a MAR of \$403.84.

- Procedure code 20680 has status indicator Q2, for T-packaged codes; reimbursement is packaged with payment for any service with status indicator T. This code is packaged into code 27808.
- Procedure code 99218 has status indicator B, for codes not paid under OPPS—these codes may not be reported on an outpatient hospital bill (type 12x and 13x). Payment is not recommended.

The total recommended reimbursement for the disputed services is \$403.84. The insurance carrier paid \$130.87. The amount due is \$272.97. 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 \$272.97 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 Texas Mutual must remit

to Hunt Regional Medical Center \$272.97 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

December 15, 2021

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 electrónico CompConnection@tdi.texas.gov.