



# TEXAS DEPARTMENT OF INSURANCE

## Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Texas Health of Fort Worth

**Respondent Name**

Texas Mutual Insurance

**MFDR Tracking Number**

M4-16-0408-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

October 15, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Please submit this claim for the correct allowable per ASC Rule 134:402:Outpatient Hospital Rule 134.03, HCPS's are payable at 200% of the correct fee schedule allowable."

**Amount in Dispute:** \$308.96

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The requestor billed code 74177. Texas Mutual believes it paid this code correctly at \$759.15. The requestor billed code 99361 an add-on code to 99360. However, the requestor did not bill code 99360. Texas Mutual declined to issue payment of the add-on code when the primary code was not billed. The requestor billed code 99375, an add-on code for each additional sequential IV push of normal saline while code 96375 was for sodium chloride, i.e. normal saline. For this reason, Texas Mutual bundled the payment for this code to 96374. No additional payment is due."

**Response Submitted by:** Texas Mutual Insurance

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 25, 2014	74177, 96361, 96375	\$308.96	\$0.00

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - P12 – Workers compensation jurisdictional fee schedule adjustment
  - 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
  - 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
  - 767 – Reimbursed per O/P FG at 200% separate reimbursement for implantables (including certification)not requested
  - B15 – This service/procedure requires that a qualifying service/procedure be received and covered the qualifying other service/procedure has not been received/adjudicated
  - 236 – This billing code is not compatible with another billing code provided on the same day according to NCCI or workers compensation state regulations/fee schedule requirements

### **Issues**

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

### **Findings**

1. This dispute relates to outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (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 with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
  - Procedure code 74177 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC if OPPS criteria are met; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. These services are classified under APC 0334, which, per OPPS Addendum A, has a payment rate of \$390.13. This amount multiplied by 60% yields an unadjusted labor-related amount of \$234.08. This amount multiplied by the annual wage index for this facility of 0.9512 yields an adjusted labor-related amount of \$222.66. The non-labor related portion is 40% of the APC rate or \$156.05. The sum of the labor and non-labor related amounts is \$378.71. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$378.71. This amount multiplied by 200% yields a MAR of \$757.42.
  - Procedure code 96361 is an add-on code that represents services performed subsequent to another initial service. Per Medicare policy, this code is not eligible for payment unless reported with an appropriate primary procedure. Review of the submitted documentation finds that an appropriate primary procedure was not reported. Reimbursement is not recommended.

- Per Medicare policy, procedure code 96375 is an add-on code. Add-on codes are eligible for payment if an acceptable primary procedure code is also eligible for payment to the same practitioner for the same patient on the same date of service. Separate payment is not recommended as the primary procedure was not payable.

3. The total allowable reimbursement for the services provided on this date of service is \$1,949.46. This amount less the amount previously paid by the insurance carrier of \$1,953.93 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

**ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

November 4, 2015  
Date

**YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**