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
Doctors Hospital at Renaissance

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-17-3083-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 19, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $425.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $4,657.37."

Response Submitted by: ESIS, PO Box

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 21 – 22, 2016	96460, 96374	$425.36	$0.00

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient facility services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 222 – Charge exceeds Fee Schedule allowance
   - 402 – The appropriate modifier was not utilized

- 411 – National Correct Coding Initiative edit – either mutually exclusive of or integral to another service performed on the same day
- 774 – CMS OPPS STVX-packaged service is packaged into the payment for the service(s) with status indicator S,T,V or X and no separate payment is made for the STVX-packaged service
- 785 – Items and/or services are packaged into APC rate. Therefore there is no separate APC payment
- ANSI 193 – Original payment decision is being maintained. This claim was processed properly the first time
- ANSI 236 – This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the NCCI edits or work comp state regs/fee schedule requirements
- ANSI 197 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- P12 – Workers compensation jurisdictional fee schedule adjustment

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking additional reimbursement in the amount of $425.36 for Codes 96460 – "Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device" and 96374 – "Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug" rendered on September 22, 2016.

   The insurance carrier denied the disputed services with claim adjustment reason code 411 – "National Correct Coding Initiative edit – either mutually exclusive of or integral to another service performed on the same day" for code 96374 and 774 – "CMS OPPS STVX-packaged service is packaged into the payment for the service(s) with status indicator S,T,V or X and no separate payment is made for the STVX-packaged service" for code 96460.

   28 Texas Administrative Code §134.403 states in pertinent parts,

   > (b) (3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.
   >
   > And,
   >
   > (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

   Review of Addendum B at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates-Items/2016-July-Addendum-B.html?DLPage=2&DLEntries=10&DLSort=2&DLSortDir=descending finds Code 96460 has a status indicator which per the CMS Claims Processing Manual, Chapter 4, Section 10.1.1 is "*The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged*" of Q1 or *Packaged APC payment if billed on the same date of service as a HCPC code assigned status indicator "S," "T," r "V."*

   The carrier's denial is therefore supported as the primary code 29881 – "Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed" has a status indicator of "T." Therefore, no additional payment is recommended.

Review of the National Correct Coding Initiative Edits at www.cms.gov, finds an edit exists between code 29881 and 96374 and no modifier was submitted to indicate the procedure was distinct or independent of the primary procedure. The carrier's denial is supported no additional payment is 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Peggy Miller Medical Fee Dispute Resolution Officer	July 26, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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. **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.