TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
OAKBEND MEDICAL CENTER

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE

MFDR Tracking Number
M4-18-0569-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 30, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In a letter from Liberty Mutual Managed Care dated December 29, 2016 and open reduction internal fixation surgery ('ORIF') was authorized. However, after the patient was administered anesthesia . . . the fracture appeared to be better than the pre-operative x-ray showed . . . [The surgeon] decided to not go through with the ORIF surgery leaving the fracture as-is. . . . The Hospital billed Liberty Mutual and used the modifier -74 to indicate the ORIF procedure not being carried out. However, Liberty Mutual denied the bill. . . . I spoke with a representative who indicated the bill was ultimately denied because Liberty Mutual's position is modifier -74 is inappropriate and not payable. . . . the only payment issued was for the x-ray. . . . the primary denial reason is denial code X263 on the Explanation of Benefits, stating 'the code billed does not meet the level/description of the procedure performed/documented…' . . . Liberty Mutual's denial reason is improper in this case. The January 2017 update of the Hospital Outpatient Prospective Payment System specifically states: 'Modifier -74 is used by the facility… to indicate that a planned surgical or diagnostic procedure was discontinued, partially reduced or cancelled at the physician's discretion after the administration of anesthesia. …This modifier code was created so that the costs incurred by the hospital to initiate the procedure (preparation of the patient, procedure room, recovery room) could be recognized for payment even though the procedure was discontinued prior to completion.' CPT code 24685LT74 is proper under the rules because the patient was provided with anesthesia and additional preparations were made, but [the surgeon] did not follow through with the planned surgery. . . . Additionally, the Hospital intended to provide the authorized procedure to treat the patient's work injury, and would have completed the surgery had the surgeon not used his discretion to determine that an extensive ORIF surgery as not medically necessary at the time. Therefore, our position is that he Hospital should be reimbursed in accordance with the fee guidelines, and not penalized for the doctor's conservative judgment to not subject the patient to an unnecessary, more extensive procedure. "

Amount in Dispute: $22,578.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is our position that there were no extenuating circumstances or circumstances that threatened the well being of the patient. [the surgeon] billed CPT 24300 and was reimbursed for same. [the surgeon] made a decision after the manipulation of elbow and review under fluoroscopy that the elbow and ulnar collateral ligament were stable, and made a decision to leave the fracture as is."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 24, 2017	Outpatient Hospital Services	$22,578.77	$10,108.49

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 acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §133.240 sets out requirements for paying or denying medical bills.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES. (U634)
   - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
   - X263 – THE CODE BILLED DOES NOT MEET THE LEVEL/DESCRIPTION OF THE PROCEDURE PERFORMED/DOCUMENTED. CONSIDERATION WILL BE GIVEN WITH CODING THAT REFLECTS THE DOCUMENTED PROCEDURE. (X263)
   - X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
   - 193 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
   - W3 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES
   - PA – FIRST HEALTH
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
   - P300 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
   - MOPS – SERVICES REDUCED TO THE OUTPATIENT PERSPECTIVE PAYMENT SYSTEM (OPPS).
   - P303 – THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)
   - MSIN – THIS IS A PACKAGED ITEM. SERVICES OR PROCEDURES INCLUDED IN THE APC RATE, BUT NOT PAID SEPARATELY.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code X263 – "THE CODE BILLED DOES NOT MEET THE LEVEL/DESCRIPTION OF THE PROCEDURE PERFORMED/DOCUMENTED. CONSIDERATION WILL BE GIVEN WITH CODING THAT REFLECTS THE DOCUMENTED PROCEDURE. (X263)"

   The division's *Hospital Facility Fee Guideline—Outpatient*, at 28 Texas Administrative Code §134.403(d) requires that for coding, billing, reporting, and reimbursement of covered health care, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions as specified in the rules.

   Rule §134.403(d)(3) further requires that, "whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later."

   Rule §134.403(b)(3) defines *Medicare payment policy* to mean "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."

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, §20.6.4 - **Use of Modifiers for Discontinued Services**, states that:

> Modifier -74 is used by the facility to indicate that a procedure requiring anesthesia was terminated after the induction of anesthesia or after the procedure was started (e.g., incision made, intubation started, scope inserted) due to extenuating circumstances or circumstances that threatened the well being of the patient. This modifier may also be used to indicate that a planned surgical or diagnostic procedure was discontinued, partially reduced or cancelled at the physician's discretion after the administration of anesthesia. . . . This modifier code was created so that the costs incurred by the hospital to initiate the procedure (preparation of the patient, procedure room, recovery room) could be recognized for payment even though the procedure was discontinued prior to completion.

With regard to effect on payment, the Manual further states:

> Procedures that are discontinued, partially reduced or cancelled after the procedure has been initiated and/or the patient has received anesthesia will be paid at the full OPPS payment amount. Modifier -74 is used for these procedures.

The respondent's position statement asserts, "there were no extenuating circumstances or circumstances that threatened the well being of the patient."

While this at first blush sounds like a medical necessity argument, the insurance carrier did not ever deny the services citing a reason related to medical necessity. Furthermore, 28 Texas Administrative Code §133.240(b) requires that the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134. The submitted documentation supports that the disputed services were preauthorized; therefore, per Rule §133.240(b), retrospective review of the medical necessity of services would *not* be appropriate after authorization had been obtained following utilization review.

Moreover, Rule §133.307(d)(2)(F) requires that the insurance carrier's response "shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." No information was found to support that the insurance carrier ever issued a denial code related to medical necessity, or presented to the health care provider any such defense or denial reason prior to the filing of the request for medical fee dispute resolution. Failure of the carrier to raise all appropriate denial reasons and defenses during the bill review and reconsideration process—prior to the filing of Medical Fee Dispute request—is grounds for the division to find a waiver of any such new defenses presented at MFDR. Accordingly, the division concludes that medical necessity is not at issue in this dispute; and any such new defenses or denial reasons will not be considered in this review.

The clinical review specialist that responded on behalf of the insurance carrier quotes the portion of the Medicare payment policy in *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 4, §20.6.4, which states:

> Modifier -74 is used by the facility to indicate that a procedure requiring anesthesia was terminated after the induction of anesthesia or after the procedure was started (e.g., incision made, intubation started, scope inserted) *due to extenuating circumstances or circumstances that threatened the well being of the patient*.

While the respondent may debate whether the potential of performing unnecessary surgery constitutes an *extenuating circumstance* or a *threat to the well being of the patient*, the Medicare payment policy further states:

> This modifier may *also* be used to indicate that a planned surgical or diagnostic procedure was discontinued, partially reduced or cancelled *at the physician's discretion* after the administration of anesthesia.

The division thus finds the requestor has met the requirements of the Medicare payment policy: the surgeon, using his discretion, cancelled, discontinued or partially reduced the planned (and preauthorized) surgery after administration of anesthesia.

The division further notes that the Medicare payment policy explains:

> This modifier code [modifier -74] was created so that the costs incurred by the hospital to initiate the procedure (preparation of the patient, procedure room, recovery room) could be recognized for payment even though the procedure was discontinued prior to completion.

The requestor asserts that:

> CPT code 24685LT74 is proper under the rules because the patient was provided with anesthesia and additional preparations were made, but [the surgeon] did not follow through with the planned surgery. . . . the Hospital intended to provide the authorized procedure to treat the patient's work injury, and would have completed the surgery had the surgeon not used his discretion to determine that an extensive ORIF surgery as not medically necessary at the time. Therefore, our position is that he Hospital should be reimbursed in accordance with the fee guidelines, and not penalized for the doctor's conservative judgment to not subject the patient to an unnecessary, more extensive procedure.

The division agrees. Review of the submitted documentation finds the requestor's position is supported, while the respondent's reasons for denial of payment are not supported. The disputed services will therefore be reviewed for payment according to applicable division rules and fee guidelines.

2. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying the effective Medicare Outpatient Prospective Payment System (OPPS) formula and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services (CMS) at http://www.cms.gov.

   Rule §134.403(f)(1) requires that the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent. Implantables were not supplied as part of the procedure, and separate payment was not requested.

   Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) to billed services based on procedure code and supporting documentation. The APC determines the payment rate. Payment for ancillary items and services is packaged into the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure codes J7030, J7120, J0690, J3010, J2250, J2704 and J2405 have status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
   - Procedure code 73070 has status indicator Q1, denoting packaged codes; reimbursement for this service is packaged with payment for the comprehensive procedure code 24685, billed on the same claim.
   - Procedure code 24685 has status indicator J1, denoting packaged services paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (except those with status indicator F, G, H, L or U; certain inpatient and preventive services, ambulance, and mammography). This code is assigned APC 5114. The OPPS Addendum A rate is $5,221.57, which is multiplied by 60% for an unadjusted labor-related amount of $3,132.94, which is in turn multiplied by the facility wage index of 0.9653 for an adjusted labor amount of $3,024.23. The non-labor related portion is 40% of the APC rate, or $2,088.63. The sum of the labor and non-labor portions is $5,112.86. This service does not exceed the cost thresholds required to qualify for outlier payment. The Medicare facility specific amount of $5,112.86 is multiplied by 200% for a MAR of $10,225.72.

3. The total recommended reimbursement for the disputed services is $10,225.72. The insurance carrier has paid $117.23, leaving an amount due to the requestor of $10,108.49. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $10,108.49.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $10,108.49, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	December 8, 2017
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 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.