TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION AMENDMENT

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH FORT WORTH

Respondent Name
TRAVELERS CASUALTY & SURETY COMPANY

MFDR Tracking Number
M4-18-3346

Carrier's Austin Representative
Box Number 05

MFDR Date Received
May 14, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT 96361 & 96375 have no conflicting codes on this claim & 96374 is separately payable as billed with modifier 59."

Original Amount in Dispute: $130.27

Amount in Dispute after Additional Payment Issued on May 30, 2018: $20.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the documentation and determined the Provider is entitled to supplemental reimbursement for the disputed services."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 13, 2017	Hospital Outpatient Services	$20.45	$20.45

FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

This medical fee dispute is amended pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 hospital facility fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – PAYMENT ADJUSTED BECAUSE 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.
   - 56 – SIGNIFICANT, SEPARATELY IDENTIFIABLE E/M SERVICE RENDERED.
   - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE.

- 86 – SERVICE PERFORMED WAS DISTINCT OR INDEPENDENT FROM OTHER SERVICES PERFORMED ON THE SAME DAY.
- 5142 - Message Code: After review, the therapeutic and/or diagnostic injection service billed is not reimbursable based on AMA guidelines. The billed service is considered inclusive into the value of the primary service(s) billed.
- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- 947 – UPHELD. NO ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED.
- 1001 - Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
- 4097 - PAID PER FEE SCHEDULE; CHARGE ADJUSTED BECAUSE STATUTE DICTATES ALLOWANCE IS GREATER THAN PROVIDER'S CHARGE.

Issues

1. What is the maximum allowable reimbursement (MAR) for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

Texas Health of Fort Worth, a hospital, billed Travelers, a workers' compensation insurance carrier, for payment of outpatient hospital services provided to a covered injured employee. Travelers paid a total of $1,514.42. Texas Health was dissatisfied with the total payments after reconsideration. Texas Health then filed for medical fee dispute resolution and asked for an additional $130.27.

In its response to medical fee dispute, Travelers noted that it was making a "supplemental payment." Texas Health later confirmed that it had received an additional payment of $109.82 which brought the disputed balance down to $20.45. In an email to the Division, Texas Health stated that it still wanted to pursue payment for the remaining balance.

In the following analysis, the Division will calculate the maximum allowable reimbursement (MAR) for the service in dispute to decide whether additional payment in the amount of $20.45 is due.

1. 28 Texas Administrative Code §134.403, establishes the maximum allowable reimbursement (MAR) for the services in dispute. Regardless of billed amount, reimbursement is calculated by taking the Medicare facility specific amount and multiplied it by 200 percent.

   Medicare first assigns a status indicator to each HCPCS code. The status indicator in turn defines whether a service is payable or whether it is not payable. If payable, payment will be based either on the geographically adjusted Ambulatory Payment Classification (APC) for the code, or it will be calculated based on a different Division fee schedule such as the physician fee schedule. Bothe the status indicator descriptions and the APC pricing files are found in the annual Hospital Outpatient Regulations and Notices posted on the CMS website.[1]

   The total allowable for each of the disputed services is calculated as follows:

   - Procedure code 74177 has a status indicator code of Q3, payment is allowed. The OPPS Addendum A APC rate is $265.02, multiplied by 60% for an unadjusted labor amount of $159.01, and multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $152.94. The non-labor portion is 40% of the APC, or $106.01. The sum of the labor and non-labor portions is the Medicare facility specific amount of $258.95. This is multiplied by 200% for a MAR of $517.90.
   - Procedure code 96361 has status indicator code of S, this procedure is not subject to reduction. This code is classified under APC 5691. The Addendum A APC rate is $34.78, multiplied by 60% for an unadjusted labor amount of $20.87, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $20.07. The non-labor portion is 40% of the APC rate, or $13.91. The sum of the labor and non-labor portions is the Medicare facility specific amount of $33.98. This is multiplied by 200% for a MAR of $67.96.

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[1] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html

- Procedure code 96374 has a Correct Coding Initiative (CCI) edit conflict with code 74177 billed for the same date. A modifier may be used to differentiate the services. Separate payment is allowed if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier (-59). Payment is allowed. Procedure code 96374 has status indicator S for procedures not subject to reduction. This code is classified under APC 5693. The OPPS Addendum A rate is $179.77, multiplied by 60% for an unadjusted labor amount of $107.86, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $103.74. The non-labor portion is 40% of the APC rate, or $71.91. The sum of the labor and non-labor portions is the Medicare facility specific amount of $175.65. This is multiplied by 200% for a MAR of $351.30.
- Procedure code 96375 has status indicator S, for procedures not subject to reduction. This code is classified under APC 5691. The OPPS Addendum A rate is $34.78, multiplied by 60% for an unadjusted labor amount of $20.87, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $20.07. The non-labor portion is 40% of the APC rate, or $13.91. The sum of the labor and non-labor portions is the Medicare facility specific amount of $33.98. This is multiplied by 200% for a MAR of $67.96.
- Procedure code 99284 has status indicator J2, for outpatient visits. This code is classified under APC 5024. The OPPS Addendum A rate is $332.41, multiplied by 60% for an unadjusted labor amount of $199.45, multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $191.83. The non-labor portion is 40% of the APC rate, or $132.96. The sum of the labor and non-labor portions is the Medicare facility specific amount of $324.79. This is multiplied by 200% for a MAR of $649.58.

The total, maximum allowable reimbursement (MAR) for the services is therefore $1,654.70.

The Division's fee guideline maximum allowable amount is $1,654.70. Travelers paid a grand total of $1,624.24. Texas Health is seeking an additional $20.45. This amount is recommended for payment.

Conclusion

For the reasons stated above, the division finds that Travelers should reimburse Texas Health the additional $20.45 as requested.

ORDER

Based on the submitted information, 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 $20.45, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Martha Luévano	August 31, 2018
Signature	Director for Medical Fee Dispute Resolution	Date

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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.