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 HEB

Respondent Name
AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number
M4-18-3518-01

Carrier's Austin Representative
Box Number: 37

MFDR Date Received
May 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This bill and 2 reconsideration requests have been denied for invalid ICD-10 code [redacted]. This diagnosis code is not used on this bill."

Amount in Dispute: $8,853.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider is billing Revenue Code 361 with no CPT code, therefore, an ICD code is required and was not billed. Upon appeal provider added ICD procedure codes including invalid code [redacted]."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
June 1, 2017	Outpatient Hospital Services	$8,853.57	$5,594.26

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 hospital facility fee guideline for outpatient services.
3. 28 Texas Administrative Code §133.10 sets out division requirements regarding billing forms and formats.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 421 - Resubmit bill with appropriate ICD-10 principal procedure code: <InvPCSs>
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - ETBR – A technical Bill Review (TBR) has been performed.
   - 18 – Duplicate claim/service
   - 148 – This procedure on this date was previously reviewed.

Issues

1. Are the insurance carrier's reasons for denial 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 codes:
   - 421 - Resubmit bill with appropriate ICD-10 principal procedure code: <InvPCSs>
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

   Review of the documentation submitted by the respondent finds no information to support these payment denial reasons.

   Review of the documentation submitted by the requestor finds no submission billing errors and no information lacking which is needed to adjudicate the claim.

   28 Texas Administrative Code §133.10 sets out division requirements regarding billing forms and formats.

   Rule §133.10(f) sets out division requirements for completing a medical bill submitted on paper, stating:

   > All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form.

   Rule §133.10(f)(2) sets out division requirements for the data content or data elements needed to complete an institutional medical bill.

   Rules §133.10(f)(2)(M M) states that principal procedure code and date (UB-04/field 74) is required when submitting an inpatient medical bill and a procedure was performed;

   Rules §133.10(f)(2)(NN) states that other procedure codes and dates (UB-04/fields 74A - 74E) are required when submitting an inpatient medical bill and other procedures were performed;

   The division notes that ICD-10-PCS procedure codes are required in fields 74 and 74A – 74E *only* on an *inpatient* medical bill.

   Review of the bill type (field 4) and other information on the claim finds the bill is for *outpatient* services — not *inpatient*; consequently, division rules do not require ICD procedure codes to be present on the bill.

   The respondent's position statement asserts:

   > Provider is billing Revenue Code 361 with no CPT code, therefore, an ICD code is required and was not billed. Upon appeal provider added ICD procedure codes including invalid code [redacted].

   The insurance carrier did not submit any information to support its contention that an ICD code was required or missing from the bill. ICD-10-CM diagnosis codes were found present on the bill in fields 66 and 70. And, as noted above, Rule §133.10(f)(2) does not require ICD-10-PCS procedure codes on outpatient medical bills.

   Furthermore, despite the respondent's assertion, code [redacted] was not found anywhere on the bill. Nor did the respondent explain or justify the position that such a code would render the entire bill unpayable, even if such a code had been present.

   The insurance carrier's denial reasons are not supported. The disputed services will therefore be reviewed for payment in accordance with applicable division rules and fee guidelines.

2. This dispute regards outpatient surgery 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 Medicare Outpatient Prospective Payment System (OPPS) formulas and factors, as published annually in the Federal Register, with modifications set out in the rules. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200 percent for the disputed outpatient facility charges. Separate reimbursement for implants was not requested.

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

Reimbursement for the disputed services is calculated as follows:

- Procedure code 49520 has status indicator J1, denoting packaged services paid at a comprehensive rate. All covered services are packaged with the primary "J1" procedure (excluding certain exceptions that are not present on this bill). This procedure is assigned APC 5341. The OPPS Addendum A rate is $2,862.74, which is multiplied by 60% for an unadjusted labor-related amount of $1,717.64, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $1,652.03. The non-labor portion is 40% of the APC rate, or $1,145.10. The sum of the labor and non-labor portions is $2,797.13. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $2,797.13 is multiplied by 200% for a MAR of $5,594.26.
- Payment for all other services on the bill is packaged with the primary comprehensive J1 service according to Medicare policy regarding comprehensive APCs. Reimbursement for all items is included in the payment for the primary procedure. Please see *Medicare Claims Processing Manual* Chapter 4 §10.2.3 for further details.

3. The total allowable reimbursement for the disputed services is $5,594.26. The insurance carrier paid $0.00. The amount due is $5,594.26. This amount is recommended.

Conclusion

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 not all the evidence was 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 $5,594.26.

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 $5,594.26, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	June 15, 2018
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.

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.