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 DALLAS

Respondent Name
MASTEC, INC.

MFDR Tracking Number
M4-18-3890-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
June 11, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review CPT codes 96374 and 96375 these are not packaged codes. Both codes have a status indicator of S and are paid separately under OPPS."

Amount in Dispute: $208.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are standing on our denial."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 23, 2018	Outpatient Hospital Services	$208.64	$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 hospital facility fee guideline for outpatient 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.
   - 773 – Reimbursement is in accordance with the TDI Workers Compensation State Fee Schedule Adjustment and Guidelines.
   - 785 – Items and/or services are packaged into APC rate. Therefore there is no separate APC payment.
   - 881 – This item is an integral part of an emergency room visit or surgical procedure and is therefore included in the reimbursement for the facility/APC rate.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly the first time.
- 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI or workers compensation state regulations /fee schedule requirements.
- 97 – 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.
- CIQ377 – Additional recommendation is based upon additional supporting documentation received.
- CIQ378 – This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time.

Issues

1. What is the recommended payment for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient 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 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 emergency room services.

   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 codes 73590 and 90471 have status indicator Q1, denoting STV-packaged codes; reimbursement is included with payment for any service assigned status indicator S, T or V. Payment for these services is packaged with Status T procedure code 13121 performed on the same date.
   - Procedure code 13121 has status indicator T, denoting procedures subject to multiple-procedure reduction. This code is assigned APC 5053. The OPPS Addendum A rate is $488.20, multiplied by 60% for an unadjusted labor amount of $292.92, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $285.77. The non-labor portion is 40% of the APC rate, or $195.28. The sum of the labor and non-labor portions is $481.05. The Medicare facility specific amount of $481.05 is multiplied by 200% for a MAR of $962.10.
   - Per Medicare payment policy regarding correct coding (CCI edits), procedure codes 96374 and 96375 may not be reported with code 13121 billed on the same claim. Reimbursement for this service is included with payment for the primary procedure. Separate payment is not recommended.
   - Per Medicare policy, procedure code 99283 may not be reported with code 90471 billed on the same claim. Reimbursement for this service is included with payment for the primary procedure. 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. Separate payment is allowed. Procedure code 99283 has status indicator J2, denoting outpatient visits (subject to comprehensive packaging if criteria are met). This code is assigned APC 5023. The OPPS Addendum A rate is $219.10, multiplied by 60% for an unadjusted labor amount of $131.46, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $128.25. The non-labor portion is 40% of the APC rate, or $87.64. The sum of the labor and non-labor portions is $215.89. The Medicare facility specific amount of $215.89 is multiplied by 200% for a MAR of $431.78.
   - Procedure codes 90715, J0690 and J3010 have status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.

2. The total recommended reimbursement for the disputed services is $1,393.88. The insurance carrier paid $1,630.92. Additional payment is not 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 not all the evidence was discussed, it was considered.

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

	Grayson Richardson	July 13, 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.