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 FORT WORTH

Respondent Name
TRUMBULL INSURANCE COMPANY

MFDR Tracking Number
M4-18-3945-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 11, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT codes have their own separate APC payment rate and are to be paid at 100%. These are not packaged codes."

Amount in Dispute: $418.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services were processed in accordance with Texas Fee Schedule & Guidelines"

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
December 8, 2017	Outpatient Hospital Services: 96374, 96375	$418.43	$418.43

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:
   - 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.
   - QS301 – THIS SERVICE IS INCLUDED IN PRIMARY OR MORE EXTENSIVE PROCEDURE.
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

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 82565, 83605 and 81001 have status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 74177 (CT with contrast) is assigned APC 5571 with status indicator S, denoting significant procedures not subject to reduction. The OPPS Addendum A rate is $265.02, multiplied by 60% for an unadjusted labor amount of $159.01, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $153.22. The non-labor portion is 40% of the APC rate, or $106.01. The sum of the labor and non-labor portions is $259.23, multiplied by 200% for a MAR of $518.46.
   - Per Medicare correct coding policy (CCI edits), procedure code 96374 (intravenous push injection) may not be reported with code 74177 (CT scan with contrast) billed on the same claim. Reimbursement for injection is included with payment for the CT scan, because contrast material is typically *injected* as *part* of this CT service. The injection of contrast should not be unbundled as a separate code, simply to receive extra payment. However, a modifier may be used to differentiate the services if the injection is not related to the CT scan or contrast delivery. Separate payment is allowed if a modifier is used appropriately. The provider billed this service with modifier 59, to indicate a separately identifiable service. Review of the medical records finds the IV push injection(s) were *not* related to the CT scan or contrast agent and thus the use of modifier 59 to override the CCI edit is supported. Procedure code 96374 is assigned 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 0.9636 for an adjusted labor amount of $103.93. The non-labor portion is 40% of the APC rate, or $71.91. The sum of the labor and non-labor portions is $175.84, multiplied by 200% for a MAR of $351.68.
   - Procedure code 96375 is an add-on code denoting an additional drug or agent added to the IV push injection. While this code would not be supported if the underlying 96374 code were subject to a CCI edit, as above the provider billed this code with modifier 59 to distinguish separately identifiable services. Review of the medical records finds again that this modifier is supported. This code is assigned APC 5691 with an OPPS Addendum A rate of $34.78, multiplied by 60% for an unadjusted labor amount of $20.87, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $20.11. The non-labor portion is 40% of the APC rate, or $13.91. The sum of the labor and non-labor portions is $34.02, multiplied by 200% for a MAR of $68.04.
   - Procedure code 99284 has status indicator J2 for outpatient visits. This code is assigned APC 5024 with an OPPS Addendum A rate of $332.41, multiplied by 60% for an unadjusted labor amount of $199.45, which is multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $192.19. The non-labor portion is 40% of the APC rate, or $132.96. The sum of the labor and non-labor portions is $325.15. The Medicare facility specific amount of $325.15 is multiplied by 200% for a MAR of $650.30.
   - Procedure codes J2270, J2405, Q9963 and Q9967 have status indicator N for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for other services.
2. The total recommended reimbursement for the disputed services is $1,588.48. The insurance carrier paid $1,167.46. The requestor is seeking additional reimbursement of $418.43. This amount is recommended.

Conclusion

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 $418.43.

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 $418.43, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	July 3, 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.