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
TRAVELERS INDEMNITY COMPANY

MFDR Tracking Number
M4-18-4214-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
July 2, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT 96365 & 96375 - Per Medicare billing guidelines, these 2 codes are separately payable as billed and 'XU' is an acceptable modifier."

Amount in Dispute: $485.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the reimbursement for the diagnostic testing was included in the primary service rendered. CPT codes 963765 and 96375 are inclusive to CPT code 99283"

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 11, 2017	Outpatient Hospital Services CPT codes 96365 and 96375	$485.40	$188.00

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:
   - 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.
   - 4915 - THE CHARGE FOR THE SERVICES REPRESENTED BY THE REVENUE CODE ARE INCLUDED/BUNDLED INTO THE TOTAL FACILITY PAYMENT AND DO NOT WARRANT A SEPARATE PAYMENT OR THE PAYMENT STATUS INDICATOR DETERMINES THE SERVICE IS PACKAGED OR EXCLUDED FROM PAYMENT.
   - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 107 – CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT PREVIOUSLY PAID OR IDENTIFIED ON THIS CLAIM.

- 974 – THIS PROCEDURE IS INCLUDED IN THE BASIC ALLOWANCE OF ANOTHER PROCEDURE
- 292 – THIS PROCEDURE CODE IS ONLY REIMBURSED WHEN BILLED WITH THE APPROPRIATE INITIAL BASE CODE.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 1115 - We find the original review to be accurate and are unable to recommend any additional allowance.

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 payment for the disputed services with claim adjustment reason 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.
   - 4915 - THE CHARGE FOR THE SERVICES REPRESENTED BY THE REVENUE CODE ARE INCLUDED/BUNDLED INTO THE TOTAL FACILITY PAYMENT AND DO NOT WARRANT A SEPARATE PAYMENT OR THE PAYMENT STATUS INDICATOR DETERMINES THE SERVICE IS PACKAGED OR EXCLUDED FROM PAYMENT.
   - 107 – CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT PREVIOUSLY PAID OR IDENTIFIED ON THIS CLAIM.
   - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
   - 974 – THIS PROCEDURE IS INCLUDED IN THE BASIC ALLOWANCE OF ANOTHER PROCEDURE
   - 292 – THIS PROCEDURE CODE IS ONLY REIMBURSED WHEN BILLED WITH THE APPROPRIATE INITIAL BASE CODE.

   Per Medicare correct coding policies (CCI edits) procedure codes 96365 and 96375 may not be reported with procedure code 12001 performed on (and billed for) the same date. However, the edit allows the use of a modifier to distinguish separate services. The provider billed codes 96365 and 96375 with modifier XU, "Unusual Non-Overlapping Service, distinct services that do not overlap usual components of the main service." Modifier XU allows override of specific CCI edits, if the modifier is appropriately used and supported by the medical record. Conflicting procedure code 12001 involves wound closure (in this case after removal of foreign object from the foot). The description of code 12001 includes injection of local anesthetic at wound site (in the medical record, the local anesthetic used is listed as bupivacaine — which was not separately billed). Code 12001 also includes irrigation with saline. Review of the medical record finds the IV infusion performed under code 96365 involved morphine for general pain relief not specific to performing the wound closure. Code 96375 involved administration of antibiotic. The insurance carrier did not address the use of the XU modifier in the explanation of benefits (EOB) or in their position statement. Neither the administration of morphine for generalized pain relief nor antibiotic for prevention of infection appears to overlap any of the usual components described as included in the definition of code 12001. Accordingly, based on the preponderance of the submitted evidence, the division finds the XU modifier to be supported. Separate payment is therefore allowed.

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

2. 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 services is calculated as follows:

- Procedure codes 36415 and 85025 have status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services.
- Procedure codes 73630 and 12001 have status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for services with status indicator S performed on the same date.
- Procedure codes 90715, J0690, J2270 and J2405 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.
- Procedure code 96365 represents initial IV infusion of single drug up to 1 hour. Per Medicare's correct coding policies (CCI edits), procedure code 96365 may not be reported with code 12001 billed on the same claim. Reimbursement for this service is included with payment for the primary procedure when elements of this service overlap with the usual components of the primary procedure. A modifier may be used to differentiate services. Separate payment is allowed if a modifier is used appropriately. The requestor billed the disputed service with modifier XU, "Unusual Non-Overlapping Service, distinct services that do not overlap usual components of the main service." Modifier XU overrides the CCI edit if the modifier is appropriate and supported by the medical record. Conflicting code 12001 involves wound closure (in this case after removal of a foreign object from the foot). The description of code 12001 includes injection of local anesthetic at wound site (in the medical record, the local anesthetic used is listed as bupivacaine — which was not separately billed). Code 12001 also includes irrigation with saline. Review of the medical record finds the IV infusion performed under code 96365 involved morphine for general pain relief not specific to performing the wound closure. The insurance carrier did not address the use of the XU modifier in the explanation of benefits (EOB) or in their position statement. Morphine infusion for generalized pain relief does not overlap any of the usual components listed in the description of code 12001. Based on the preponderance of evidence, the division finds the XU modifier to be supported. Separate payment is therefore allowed. Procedure code 96365 has status indicator S, denoting procedures not subject to reduction. This code 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 0.9618 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, which is multiplied by 200% for a MAR of $351.30.
- Procedure code 96375 represents sequential IV push of one additional substance. Per Medicare's correct coding policies (CCI edits), procedure code 96375 may not be reported with code 12001 billed on the same claim. Reimbursement for this service is included with payment for the primary procedure when elements of this service overlap the usual components of the primary procedure. A modifier may be used to differentiate services. Separate payment is allowed if a modifier is used appropriately. The requestor billed the disputed service with modifier XU, "Unusual Non-Overlapping Service, distinct services that do not overlap usual components of the main service." Modifier XU overrides the CCI edit if the modifier is appropriate and supported by the medical record. Conflicting code 12001 involves wound closure (after removal of a foreign object from the foot). The description of code 12001 includes injection of local anesthetic at the wound site as well as cleansing and irrigation with saline. Review of the medical record finds the additional substance administered under code 96375 involved IV piggyback of Cefazolin (ANCEF), an antibiotic. The insurance carrier did not address the use of the XU modifier in the EOB or in their position statement. Antibiotic administration does not overlap any of the usual components listed in the description of code 12001. Based on the preponderance of the evidence, the division finds the XU modifier to be supported. Separate payment is therefore allowed. Procedure code 96375 has status indicator S, denoting procedures not subject to reduction. This code is assigned 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 $33.98 multiplied by 2 units is $67.96. This is the Medicare facility specific amount, which is multiplied by 200% for a MAR of $135.92.

- Procedure code 99283 has status indicator J2 for outpatient visit. This code is assigned APC 5023. The OPPS Addendum A rate is $201.25, multiplied by 60% for an unadjusted labor amount of $120.75, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $116.14. The non-labor portion is 40% of the APC rate, or $80.50. The sum of the labor and non-labor portions is the Medicare facility specific amount of $196.64, which is multiplied by 200% for a MAR of $393.28.
- Procedure code 90471 has status indicator S for procedures not subject to reduction. This code is assigned APC 5692. The OPPS Addendum A rate is $53.17, multiplied by 60% for an unadjusted labor amount of $31.90, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $30.68. The non-labor portion is 40% of the APC rate, or $21.27. The sum of the labor and non-labor portions is the Medicare facility specific amount of $51.95, which is multiplied by 200% for a MAR of $103.90.

3. The total recommended reimbursement for the billed services is $984.40. The insurance carrier paid $796.40. The amount due is $188.00. 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 evidence presented by the requestor and respondent available 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 $188.00.

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 $188.00, 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 27, 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.