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 SPINE AND JOINT HOSPITAL

**Respondent Name**
COMMERCE & INDUSTRY INSURANCE

**MFDR Tracking Number**
M4-18-4240-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
July 9, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary**: "Our position is that the denial reasons on the Explanation of Benefits are improper and the Hospital is entitled to reimbursement."

**Amount in Dispute**: $18,473.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary**: "it is the carrier's position that this bill was paid correctly. . . . This bill was denied with 'Per fee schedule guidelines, the surgical CPT code associated with Revenue code 360 is required to process this bill.' Per TX Fee Schedule rule, an insurance carrier cannot change a billing code submitted by a health care provider."

**Response Submitted by**: AIG

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Dispute Amount | Amount Due |
|---|---|---|---|
| July 10, 2017 | Outpatient Hospital Services | $18,473.00 | $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. 28 Texas Administrative Code §133.20 sets out medical bill submission requirements for health care providers.
4. 28 Texas Administrative Code §133.240 sets out requirements when carriers pay or deny medical bills.
5. The insurance carrier denied payment for the disputed services with the following claim adjustment reasons:
   - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - This service is considered incidental, packaged, or bundled into another service or APC payment.

- This implant charge was reimbursed according to review by ForeSight Medical.
- Workers' Compensation Medical Treatment Guideline Adjustment.
- Resubmit bill with appropriate CPT, HCPCS, or NDC code.
- Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge.
- No additional reimbursement allowed after review of appeal/reconsideration.
- Per fee schedule guidelines, the surgical CPT code associated with Revenue code 360 is required to process this bill.

**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, in part, with claim adjustment reasons:
   - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - This service is considered incidental, packaged, or bundled into another service or APC payment.
   - Resubmit bill with appropriate CPT, HCPCS, or NDC code.
   - Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge.
   - Per fee schedule guidelines, the surgical CPT code associated with Revenue code 360 is required to process this bill.

   Rule §133.20(c) requires that the health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills.

   Rule §133.240(c) requires that the insurance carrier shall not change a billing code on a medical bill or reimburse health care at another billing code's value.

   Review of the submitted medical bill finds that the health care provider did not include a payable procedure code for the surgery rendered to the injured employee. There is insufficient information on the bill to establish a reimbursement amount for the services performed or to support payment.

   Review of the submitted documentation finds no request for separate payment of implantables, nor was any certification provided as required for separate reimbursement under Rule §134.403(g).

   The insurance carrier's denial reasons are supported.

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 outpatient facility services, unless a provider requests separate payment of implantables. Review of the submitted information finds that 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 codes J0690, J2250, J3010, J2704, J1100, J1885, J1170, J2550, J7120, C1713 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.

   - No other payable procedure codes were found on the medical bill.

3. Review of the medical bill finds no procedure codes under which an APC payment classification, relative value, or other fee schedule amount can be assigned to determine payment for the disputed services. There are no payable procedure codes on the bill. The insurance carrier's denial reasons are supported. Consequently, no payment can be recommended for the disputed services.

## 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 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 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.