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 STEPHENVILE

Respondent Name
ACE AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-18-4663-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
July 31, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Medicare billing guidelines, CPT 96374 & 96375 are separately payable as billed with acceptable modifier XU."

Amount in Dispute: $353.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the documentation and determined the Provider was properly reimbursed. . . . the reimbursement for the pushes was included in reimbursement for the primary service rendered, the emergency room visit."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 21, 2017	Outpatient Hospital Services 96374-XU, 96375-XU	$353.54	$353.54

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.
   - 5142 - Message Code: After review, the therapeutic and/or diagnostic injection service billed is not reimbursable based on AMA guidelines. The billed service is considered inclusive into the value of the primary service(s) billed.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 8751 - After review, the billed service is not reimbursable based on AMA guidelines. The billed service is considered inclusive into the surgical service billed.
   - 947 – UPHELD. NO ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED

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:
   - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 5142 - Message Code: After review, the therapeutic and/or diagnostic injection service billed is not reimbursable based on AMA guidelines. The billed service is considered inclusive into the value of the primary service(s) billed.
   - 8751 - After review, the billed service is not reimbursable based on AMA guidelines. The billed service is considered inclusive into the surgical service billed.

   28 Texas Administrative Code §134.403(d) requires that for coding, billing, reporting, and reimbursement of covered health care, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified by division rules.

   The respondent argues, "reimbursement for the pushes was included in reimbursement for the primary service rendered, the emergency room visit." The division notes that while emergency room visit code 99283 has a status indicator of J2, per Medicare payment policy (see *Medicare Claims Processing Manual,* Chapter 4 §10.2.3) J2 codes are not by themselves comprehensive *unless* criteria are met. J2 status codes are not paid comprehensively if a status T code is present on the bill or if less than 8 hours of observation are reported. In this case, no observation services were reported. Moreover, a T status code is also present on the bill.

   Comprehensive packaging criteria are thus not met. Visit code 99283 is not packaged or paid comprehensively with other services on this bill. Consequently, the disputed intravenous push services are not included in the payment for code 99283. Neither was any correct coding initiative (CCI) code-pair edit found between code 99283 and disputed codes 96374 or 96375. The division thus finds that payment for codes 96374 and 96375 was not included in the payment for emergency room visit code 99283.

   There is however a CCI edit conflict with code 26700, billed the same day. This CCI edit allows use of a modifier to distinguish separate services. Separate payment is allowed, despite the CCI edit, if an appropriate modifier is appended to distinguish the services as separate — so long as the medical record supports use of the modifier.

   The primary code 26700-F5 involves treatment of a dislocation of the right thumb (without anesthesia). Even though the code specifies "without anesthesia" the description of the procedure states, "anesthesia may be used if necessary." CCI edits are intended (in part) to prevent unbundling of services normally included as part of the payment for a more comprehensive procedure. Thus, anesthesia or any other service administered as part of the surgical procedure to treat the thumb would be included in the reimbursement for code 26700.

   The disputed services are 96374-XU: intravenous push injection of initial substance/drug; and 96375-XU: each additional sequential intravenous push of a new substance/drug. Both services were billed with modifier -XU, indicating distinct services that do not overlap the usual components of the main service. XU is an appropriate modifier that overrides the CCI edit if the medical documentation supports the use of the modifier.

   Review of the medical record finds the IV push injections involved administration of fentanyl, a pain medication, and ondansetron, an anti-nausea medication. The medical record shows these medications were ordered at 1:09 am, shortly after triage upon arrival at the emergency room. Review of the medical records however finds fentanyl was not the anesthesia used in performing code 26700. The procedural anesthesia used for the thumb treatment involved a *digital block* using *bupivacaine,* performed at 1:52 am, immediately before treatment of the dislocation at 1:57 am. The division thus concludes the IV push injections were given for pain and nausea control upon arrival at the emergency room and were not related to the anesthesia used in treating the dislocation. As such, the XU modifiers were billed appropriately. The nausea and pain control services were separate and did not overlap with services ordinarily provided as part of surgical code 26700. Separate reimbursement is justified in accordance with Medicare policy and division rules. The insurance carrier's denial reasons are not supported.

2. This dispute regards IV push injection 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 published 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 these disputed outpatient facility 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:

   - Per Medicare policy, procedure code 96374 should not be reported with code 26700 billed on the same date. A modifier may be used to differentiate services. Separate payment is allowed if a modifier is used appropriately. The requestor billed the service with an appropriate modifier, XU. The medical record supports the use of the modifier. Separate payment is allowed. Procedure code 96374 has status indicator S, for 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 0.9318 for an adjusted labor amount of $100.50. The non-labor portion is 40% of the APC rate, or $71.91. The cost of services does not exceed the threshold for outlier payment. The sum of the labor and non-labor portions is the Medicare facility specific amount of $172.41, which is multiplied by 200% for a MAR of $344.82.
   - Per Medicare policy, procedure code 96375 should not be reported with code 26700 billed on the same date. A modifier may be used to differentiate services. Separate payment is allowed if a modifier is used appropriately. The requestor billed the service with an appropriate modifier, XU. The medical record supports the use of the modifier. Separate payment is allowed. Procedure code 96375 has status indicator S, for 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 0.9318 for an adjusted labor amount of $19.45. The non-labor portion is 40% of the APC rate, or $13.91. The cost of services does not exceed the threshold for outlier payment. The sum of the labor and non-labor portions is the Medicare facility specific amount of $33.36, which is multiplied by 200% for a MAR of $66.72.

3. The total recommended reimbursement for disputed codes 96374-XU and 96375-XU is $411.54. The insurance carrier paid $0.00. The requestor is seeking additional reimbursement of $353.54. 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 $353.54.

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 $353.54, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

______________________	Grayson Richardson	September 7, 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 division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 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.