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 ALLIANCE

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-18-5149-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 23, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT 96374 is to be reimbursed per CMS at APC rate of $372.68 with 200% facility uplift = $745.35."

Amount in Dispute: $373.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed 2 units of code 96374-59 on its OPPS bill. However, a medically unlikely edit, a component of the NCCI Edits, allows only one unit. No additional payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 20, 2018	Outpatient Hospital Services: 96374	$373.27	$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:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 370 – THE HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 641 – THE MEDICALLY UNLIKELY EDITS (MUE) FROM CMS HAS BEEN APPLIED TO THIS PROCEDURE CODE.
   - 767 – PAID PER O/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G)
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824

Issues

1. What is the recommended reimbursement for disputed procedure code 96374?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 641 – "THE MEDICALLY UNLIKELY EDITS (MUE) FROM CMS HAS BEEN APPLIED TO THIS PROCEDURE CODE."

   28 Texas Administrative Code §134.403(d) requires that:

   > For coding, billing, reporting, and reimbursement of health care covered in this section, 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 in this section, including the following paragraphs.

   However, Rule §134.403(d)(1) further requires that:

   > Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.

   The division treatment guidelines, as well as procedures regarding dispute of medical necessity for health care, supersede conflicting policies such as the Medically Unlikely Edits (MUE) adopted by CMS in administering the Medicare program. This denial reason is therefore not supported.

   However, review of procedure code 96374 finds that the definition of the code involves intravenous push injection of a single or initial drug or substance. Subsequent injections by IV push of the same or additional drugs or substances must be billed using add-on code 96375.

   Review of the submitted medical records finds support for intravenous injection of 4 drugs or substances. The record documents that morphine was given as the initial IV injection at 1810 hours, while 3 additional substances (saline, lorazepam, and ondansetron) were injected together shortly after at 1815 hours. However, no notation was found to support that a second IV line was run. In fact, the nursing notes state specifically, "Pt did not need a second IV."

   Having reviewed the medical record, the division concludes the records do not support that 2 units of code 96374 (initial IV injection) were performed. The submitted documentation supports reimbursement for only one unit.

   28 Texas Administrative Code §134.403, requires 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.

   Procedure code 96374 code is assigned APC 5693. The OPPS Addendum A rate is $191.09, multiplied by 60% for an unadjusted labor amount of $114.65, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $110.48. The non-labor portion is 40% of the APC rate, or $76.44. The sum of the labor and non-labor portions is the Medicare facility specific amount of $186.92, which per Rule §134.403(f)(1) is multiplied by 200% for a MAR of $373.84.

2. The total recommended payment for the services in dispute is $373.84. The amount previously paid by the insurance carrier is $373.83. 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 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	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.