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 Kaufman

Respondent Name
Travelers Indemnity Co

MFDR Tracking Number
M4-19-0302-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
September 18, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above refenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $528.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As to CPT codes 96374-XS-XU and 96375-XS-XU, the use of the modifiers is inappropriate… As to CPT codes 99284 (emergency room) and 12041 (wound repair), the Carrier has reviewed the documentation and determined the Provider was properly reimbursed under the applicable Division fee schedule."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 6, 2018	Outpatient Hospital Services	$528.34	$9.58

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 reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers compensation jurisdictional fee schedule adjustment

- 8751 – After review, the billed service is not reimbursable based on AMA guidelines. The billed service is considered inclusive into the surgical service billed.

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $528.34 for outpatient hospital services rendered on April 6, 2018. The insurance carrier reduced disputed services with claim adjustment reason code P12 – "Workers' compensation jurisdictional fee schedule adjustment, 8715 – "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) states in pertinent part,

   > 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

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4. The application of this payment policy in conjunction with the Division fee guideline is discussed below.

   28 Texas Administrative Code §134.403, (f) states,

   > The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   >
   > > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   > >
   > > > (A) 200 percent; unless
   > > >
   > > > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

   Review of the medical bill finds separate payment for implants was not requested. The maximum allowable reimbursement is calculated as follows.

   Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) and Status Indicator for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates and Status Indicators in the OPPS final rules, available from www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 12041 has status indicator Q2, for T-packaged codes; reimbursement is packaged with payment for any service with status indicator T. This code is assigned APC 5052. The OPPS Addendum A rate is $310.80, multiplied by 60% for an unadjusted labor amount of $186.48, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $181.93. The non-labor portion is 40% of the APC rate, or $124.32. The sum of the labor and non-labor portions is $306.25. The Medicare facility specific amount of $306.25 is multiplied by 200% for a MAR of $612.50.

- Procedure codes 96361 XS, XU, 96374 XS, XU and 96374, XS, XU. Review of the submitted medical bill found the health care provider used the XS modifier – "Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure" and XU – "Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service."

  Review of the submitted medical record finds, the submitted diagnosis of S61.012A -
  "Laceration without foreign body of left thumb without damage to nail, initial encounter." The submitted medical record did not support a separate organ/structure was treated other than the thumb or that the services were unusual or overlapping.

  28 TAC 134.403 (d) requires use of the applicable Medicare payment policy. The Medicare payment policy found in the National Correct Coding Initiative Manual at www.cms.gov, Chapter 11 finds,

  > *CPT codes 96360-96379, 96401-96425, and 96521-96523 are reportable by physicians for services performed in physicians' offices. These drug administration services shall not be reported by physicians for services provided in a facility setting such as a hospital outpatient department or emergency department.*
  >
  > *CPT codes 96361 and 96366 are utilized to report each additional hour of intravenous hydration and intravenous infusion for therapy, prophylaxis, or diagnosis respectively. These codes may be reported only if the infusion is medically reasonable and necessary for the patient's treatment or diagnosis. They shall not be reported for "keep open" infusions as often occur in the emergency department or observation unit.*

  Based on the above, the carrier's denial is supported. No additional payment is recommended.

- Procedure code 99284 has status indicator J2, for outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed) however the criteria for comprehensive packaging is not met. This code is assigned APC 5024. The OPPS Addendum A rate is $355.53, multiplied by 60% for an unadjusted labor amount of $213.32, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $208.11. The non-labor portion is 40% of the APC rate, or $142.21. The sum of the labor and non-labor portions is $350.32. The Medicare facility specific amount of $350.32 is multiplied by 200% for a MAR of $700.64.

2. The total recommended reimbursement for the disputed services is $1,313.14. The insurance carrier paid $1,303.56. The amount due is $9.58. 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 $9.58.

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 $9.58, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 18, 2018 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, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

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 instructions on the form. 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 listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution 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.