



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Texas Health Dallas

Respondent Name

American Zurich Insurance Co

MFDR Tracking Number

M4-19-0372-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 24, 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 referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: \$1,034.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider has been reimbursed. It is not entitled to any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: March 30, 2018, Outpatient Hospital Services, \$1,034.94, \$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 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
- 236 - This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/fee schedule requirements

## Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

## Findings

1. The requestor is seeking additional reimbursement in the amount of \$1,034.94 for outpatient hospital services rendered on March 30, 2018. The insurance carrier reduced disputed services with claim adjustment reason code P12 – “Workers’ compensation jurisdictional fee schedule adjustment” and 236 – “This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/fee schedule.”

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](http://www.cms.gov), Claims processing Manual, Chapter 4. The application of this payment policy in conjunction with the Division fee guideline is discussed below.

2. 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](http://www.cms.gov).

Reimbursement for the disputed services is calculated as follows:

- Procedure codes 74177, and 71260 have status indicator Q3, for packaged codes paid through a composite APC. Codes assigned to composites are major components of a single episode of care; the hospital receives one payment for any combination of designated procedures. These services are assigned composite APC 8006, for computed tomography (CT) services including contrast. This line is assigned status indicator S, for procedures not subject to reduction. This code is assigned APC 8006. The OPSS Addendum A rate is \$500.85, multiplied by 60% for an unadjusted labor amount of \$300.51, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of \$293.18. The non-labor portion is 40% of the APC rate, or \$200.34. The Medicare facility specific amount of \$493.52 is multiplied by 200% for a MAR of \$987.04. The carrier paid \$987.04 no additional payment is recommended.
- Procedure code 96374 and 96375 were denied by the carrier as 236 – “This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/fee schedule requirements.” Review of the NCCI Policy Manual for Medicare Services found at [www.cms.gov](http://www.cms.gov), found

*CHAP11-CPTcodes90000-99999, MEDICINE, EVALUATION AND MANAGEMENT SERVICES*

*B. Therapeutic or Diagnostic Infusions/Injections and Immunizations*

*7. 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.***

The carrier’s denial is supported, no additional payment is recommended.

3. The total recommended reimbursement for the disputed services is \$2,019.54. The insurance carrier paid \$2,019.55. Additional payment is not recommended.

**Conclusion**

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**

Signature	Medical Fee Dispute Resolution Officer	October 10, 2018 Date
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### ***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.**