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 PLANO

Respondent Name
HARTFORD FIRE INSURANCE COMPANY

MFDR Tracking Number
M4-19-1031-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
October 22, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT 96374 was denied incorrectly for bundling as billed with a modifier 59 which indicates 'Distinct Procedural Service" … CPT 70450 Is paid per family Composite 8005 and reimbursed at APC rate …"

Amount in Dispute: $690.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services were processed in accordance with Texas Guidelines, Rule 134.403."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 17, 2018	Outpatient Hospital Services: 70450, 96374-59	$690.75	$90.50

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.
   - QS301 – THIS SERVICE IS INCLUDED IN PRIMARY OR MORE EXTENSIVE PROCEDURE.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - 86 – SERVICE PERFORMED WAS DISTINCT OR INDEPENDENT FROM OTHER SERVICES PERFORMED ON THE SAME DAY.
   - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
   - 863 – REIMBURSEMENT IS BASED ON THE APPLICABLE REIMBURSEMENT FEE SCHEDULE.
   - 1115 - WE FIND THE ORIGINAL REVIEW TO BE ACCURATE AND ARE UNABLE TO RECOMMEND ANY ADDITIONAL ALLOWANCE
   - 4097 - PAID PER FEE SCHEDULE; CHARGE ADJUSTED BECAUSE STATUTE DICTATES ALLOWANCE IS GREATER THAN PROVIDER'S CHARGE.

- QBCK - THE CHARGES HAVE BEEN DISCOUNTED PER REVIEW BY QMEDTRIX'S BILLCHEK SERVICE. FOR QUESTIONS REGARDING THIS ADJUSTMENT, PLEASE CALL QMEDTRIX AT 1-800-833-1993
- 18 – EXACT DUPLICATE CLAIM/SERVICE
- 247 – A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE

Issues

1. Did the requestor support the use of modifier 59 with procedure code 96374?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - QS301 – THIS SERVICE IS INCLUDED IN PRIMARY OR MORE EXTENSIVE PROCEDURE.

   Rule §134.403(d) requires that for coding, billing, reporting, and reimbursement of covered health care, 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 the Rule.

   Medicare payment policy regarding Correct Coding Initiative (CCI) edits requires that procedure code 96374 (IV push injection) may not be billed with code 23650 (shoulder dislocation treatment by manipulation) because the shoulder treatment procedure ordinarily includes services such as IV push injection for administering a variety of related medications, and the payment for these is included in the APC payment package for the primary service. A modifier is allowed to distinguish separate services, which may justify separate payment if supported by medical documentation.

   The provider billed code 96374 with modifier 59 (distinct procedural service). Per Medicare policy, if modifier 59 is used, documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same individual. However, review of the submitted medical records finds no information to support any of the above exceptions or to support how the service was distinct or separate.

   The IV push injection was for fentanyl (Sublimaze), a pre-surgery anesthesia. The injection was given in the same encounter for treatment related to the same injury. Moreover, the requestor did not explain in their position statement how the medical documentation supported modifier 59.

   Medical providers may not simply append modifier 59 to override the CCI edit solely for the purpose of receiving extra payment. The medical record must support that the service meets any exceptions to that edit that justify additional payment. And where the record is unclear, the requestor should explain in their position statement how the modifier is supported.

   Review of the submitted information finds the requestor failed to justify use of modifier 59 with code 96374. The insurance carrier's denial reasons are supported. Additional reimbursement cannot be recommended.

2. This dispute regards CT scan services, billed under procedure code 70450 and in conjunction with procedure code 72125, both subject to DWC's *Hospital Facility Fee Guideline*, Rule §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, as modified by DWC rules. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200%.

   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.

Disputed code 70450 and related code 72125 (on the same bill, but not in dispute) 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 8005, for computed tomography (CT) services without contrast.

If a composite includes multiple lines, the charges for those combined services are summed to one line. To determine outliers, a single cost for the composite is estimated from the summarized charges. Total packaged cost is allocated to the composite line in proportion to other separately paid services on the bill; however, the cost of services did not exceed the threshold for outlier payment.

The OPPS Addendum A rate for APC 8005 is $274.84, which is multiplied by 60% for an unadjusted labor amount of $164.90, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $160.88. The non-labor portion is 40% of the APC rate, or $109.94. The sum of the labor and non-labor portions is the Medicare facility specific amount of $270.82. This is multiplied by 200% for a MAR of $541.64.

The total recommended payment for the services in dispute is $541.64. The insurance carrier paid both CT codes separately at $225.57 each (instead of as a single composite payment) for a total of $451.14, leaving an amount due to the requestor of $90.50. 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 emphasizes that the findings in this decision 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 $90.50.

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 $90.50plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	November 20, 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.