



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

Starr Indemnity & Liability Co

MFDR Tracking Number

M4-19-1853-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 27, 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: \$1,425.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier reimbursed the provider in accordance with the Medical Fee Guidelines. The provider is seeking additional reimbursement with respect of the three CPT codes previously mentioned. However, the provider's request for additional reimbursement is inconsistent with the Medical Fee Guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 2, 2018	Outpatient Hospital Services	\$1,425.02	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
- 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

- MP86 – Recommended reimbursement is based on CMS Hospital Outpatient Composite APC 8006
- P300- The amount paid reflects a fee schedule reduction

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 \$1,425.02 for outpatient hospital services rendered on August 2m 2018. The insurance carrier reduced disputed services with claim adjustment reason code 97 – “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated” and MP86 – “Recommended reimbursement is based on CMS Hospital Outpatient Composite APC 8006.”

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 of 28 TAC §134.403, (f) which 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.

Allows the calculation of the services in dispute as follows:

- Procedure code 71260 was denied as MP86 – “Recommended reimbursement is based on CMS Hospital Outpatient Composite APC 8006.”

The applicable Medicare payment policy for procedure codes 74177, 70450, and **71260** finds a 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. If a composite includes multiple lines, the charges for those combined services are summed to one line. This line is assigned status indicator S, for procedures not subject to reduction. The OPPS 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 0.9636 for an adjusted labor amount of \$289.57. The non-labor portion is 40% of the APC rate, or \$200.34. The sum of the labor and non-labor portions is \$489.91. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of \$489.91 is multiplied by 200% for a MAR of \$979.82. The insurance carrier paid \$979.82 under Code 94177 which is part of the afore mentioned composite. No additional payment is recommended.

- Procedure codes 96374 and 96374 were denied as 97 – “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.” Review of the National Correct Coding Initiative Manual for Medicare services, Chapter XI, section B4 at www.cms.gov, finds,

“Because the placement of peripheral vascular access devices is integral to intravenous infusions and injections, the CPT codes for placement of these devices are not separately reportable. Thus, insertion of an intravenous catheter (e.g., CPT codes 36000, 36410) for intravenous infusion, injection or chemotherapy administration (e.g., CPT codes 96360-96368, 96374-96379, 96409-96417) shall not be reported separately.

Based TAC §134.403 (d) the carrier’s denial is supported.

2. 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.

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	December 28, 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.