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 Arlington

Respondent Name
Pacific Indemnity Co

MFDR Tracking Number
M4-19-2035-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
December 10, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…The table below indicates how the claim should be calculated and the amount due..."

Amount in Dispute: $2,306.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel hereby certifies a properly completed request for reconsideration was not received for date of service 08/02/18 prior to receipt of this request for medical fee dispute resolution."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 2, 2018	Outpatient Hospital Services	$2,306.27	$251.15

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:
   - 97A – Provider appeal
   - P14 – Pmt included in another svc/proc same day
   - P12 – Workers' compensation state fee schedule adj
   - 59 – Distinct Procedural Edit
   - R79 – CCI Standards of Medical/Surgical Practice

Issues

1. Is the respondents' position 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 respondent states "CorVel hereby certifies a properly completed request for reconsideration was not received for date of service 08/02/18 prior to receipt of this request for medical fee dispute resolution.

   Review of the submitted documents finds document with date 11/30/2018 marked as "Re-evaluation" that includes reason code 97A – "Provider appeal." The respondent's position is not supported and will not be considered in this review.

2. The requestor is seeking additional reimbursement in the amount of $2,306.27 for outpatient hospital services rendered on August 2, 2018. The insurance carrier reduced disputed services with claim adjustment reason code P12 – "Workers' compensation state fee schedule adj" and P14 – "Pmt included in another svc/proc same day."

   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.

   The maximum allowable reimbursement per the above is calculated as follows:

   - Procedure code 72125 has status indicator Q3, for packaged codes paid through a composite APC (if OPPS criteria are met). This code is assigned to composite APC 8006. This service qualifies for composite payment. The payment for composite services is calculated below.
   - Procedure code 74177 has status indicator Q3, for packaged codes paid through a composite APC (if OPPS criteria are met). This code is assigned to composite APC 8006. The payment for composite services is calculated below.
   - Procedure code 70450 has status indicator Q3, for packaged codes paid through a composite APC (if OPPS criteria are met). This code is assigned to composite APC 8006. This service qualifies for composite payment. The payment for composite services is calculated below.
   - Procedure code 71260 has status indicator Q3, for packaged codes paid through a composite APC (if OPPS criteria are met). This code is assigned to composite APC 8006. This service qualifies for composite payment. The payment for composite services is calculated below.

- Procedure codes 72125, 74177, 70450, and 71260 have status indicator Q3, for packaged codes paid through a composite APC. These services are assigned composite APC 8006, for computed tomography (CT) services including contrast. If a "without contrast" CT and a "with contrast" CT are billed together, APC 8006 is assigned instead of APC 8005. 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 Medicare facility specific amount of $489.91 is multiplied by 200% for a MAR of $979.82.
- Procedure code 96361 was denied by the carrier as 236 – "This proc or proc/mod combo not compatible." Per Chapter XI Medicine Evaluation and Management Services Cpt Codes 90000 – 99999 For National Correct Coding Initiative Policy Manual For Medicare Services found at www.cms.gov, Section (B)(16)

    B. Therapeutic or Diagnostic Infusions/Injections and Immunizations

    16. 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.

    The insurance carrier's denial is supported.

- Procedure code 96374 was denied by the carrier as 236 – "This proc or proc/mod combo not compatible" and R79 – "CCI; Standards of Medical/Surgical Practice." Per Chapter XI Medicine Evaluation and Management Services Cpt Codes 90000 – 99999 for National Correct Coding Initiative Policy Manual for Medicare Services found at www.cms.gov, Section (B)(5)

    B. Therapeutic or Diagnostic Infusions/Injections and Immunizations

    5.The administration of drugs and fluids other than antineoplastic agents, such as growth factors, antiemetics, saline, or diuretics, may be reported with CPT **codes 96360-96379. If the sole purpose of fluid administration (e.g., saline, D5W, etc.) is to maintain patency of an access device, the infusion is neither diagnostic nor therapeutic and shall not be reported separately**.

    The insurance carrier's denial is supported.

- Procedure code 96375 was denied by the carrier as 236 – "This proc or proc/mod combo not compatible" and R79 – "CCI; Standards of Medical/Surgical Practice." Per Chapter XI Medicine Evaluation and Management Services Cpt Codes 90000 – 99999 For National Correct Coding Initiative Policy Manual for Medicare Services found at www.cms.gov, Section (B)(5)

    B. Therapeutic or Diagnostic Infusions/Injections and Immunizations

    5.The administration of drugs and fluids other than antineoplastic agents, such as growth factors, antiemetics, saline, or diuretics, may be reported with CPT **codes 96360-96379. If the sole purpose of fluid administration (e.g., saline, D5W, etc.) is to maintain patency of an access device, the infusion is neither diagnostic nor therapeutic and shall not be reported separately**."

    The insurance carrier's denial is supported.

- Procedure code 99284 has status indicator J2, if 8 or more hours observation billed but as the criteria is not met this code has status indicator V. 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 0.9636 for an adjusted labor amount of $205.56. The non-labor portion is 40% of the APC rate, or $142.21. The sum of the labor and non-labor portions is $347.77. The Medicare facility specific amount of $347.77 is multiplied by 200% for a MAR of $695.54.

- Procedure code 90471 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is packaged into Code 99284 shown above as having status indicator V.

3. The total recommended reimbursement for the disputed services is $1,796.88. The insurance carrier paid $1,545.73. The amount due is $251.15. 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 $251.15.

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 $251.15, 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	January 4, 2019 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.