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 Fort Worth

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-19-2375-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
December 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: $2,509.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill has been reviewed and denial stands as the provider billed CPT 92507 and 97110 on the same DOS… Denial for 97110 states: Per NCCI, the procedure code is denied, based on standard of medical, surgical practice. Procedure included in 92507."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 4 – 29, 2018	Outpatient Hospital Services	$2,509.47	$6.45

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:
   - X397 – Provider is not within the Liberty Health Care Network, (HCN) for this customer
   - MX70 – Per NCCI, the procedure code is denied due to misuse of column 2 code with column 1 code. Procedure included in 92507
   - W3 – Additional payment made on appeal/reconsideration

- 4097 – Paid per fee schedule; charge adjusted because statute dictates allowance is greater than provider's charge
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 170 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting
- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules

Issues

1. Was the carrier's network denial maintained?
2. Was the carrier's denial of code 97110 supported?
3. What is the applicable rule for determining reimbursement for code 92507?
4. What is the reimbursement calculation of code 96152?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $2,509.47 for outpatient hospital services rendered from June 4 – 29, 2018. The insurance carrier denied disputed services with claim adjustment reason code X397 – Provider is not within the Liberty Health Care Network, (HCN) for this customer." Review of the reconsideration explanation of benefits issued October 26, 2018 did not uphold this denial. The remaining denial codes are discussed below.

2. The carrier denied code 97110 as MX70 – "Per NCCI, the procedure code is denied due to misuse of column 2 code with column 1 code. Procedure included in 92507." 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

   Review of the NCCI edits found at www.cms.gov, in effect at the time of service found "92507/Column one code and 97110/Column two code has an edit of "Misuse of column two code with column one code." The carrier's denial is supported no additional reimbursement is recommended for code 97110.

3. The applicable Division Rule pertaining to code 92507 is found in 28 TAC §134.403. The applicable sections are listed below:

   > (d) 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
   >
   > (f) 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.
   >
   > (h) For medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

   The OPPS reimbursement formula factors are found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. The specific factor is the Status Indicators. The status indicator for each of the HCPCs code listed on the DWC060 have an "A" status indicator which is defined as, "Not paid under OPPS. Paid by MACs under a fee schedule or payment system other than OPPS."

Based on the requirements of 28 TAC §134.403 (h) the applicable Division fee guideline is found in 28 TAC §134.203.

Compliance with 28 TAC §134.403 (d) requires application of the Medicare Multiple Procedure Payment Reduction (MPPR) implemented April 1, 2013. The MPPR policy may be found in the CMS Claims Processing Manual 100-04, Chapter 5, section 10.7 found at www.cms.gov. The MPPR policy was used in the calculation of the maximum allowable reimbursement shown below.

28 TAC §134.203 (c) (1) states.

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

The MAR is calculated by the DWC Conversion Factor of 58.31/Medicare Conversion Factor 35.9996 multiplied by the Medicare allowable. The calculation is as follows:

- Procedure code 92507 billed June 1, 2018 has a PE of 0.87 not the highest for this date and will be paid at the reduced rate of $63.91. 58.31/35.9996 x $63.91 = $103.52. The carrier paid $128.53. No additional payment is recommended.
- Procedure code 92507 billed June 4, 2018 has a PE of 0.87 not the highest for this date and will be paid at the reduced rate of $63.91. 58.31/35.9996 x $63.91 = $103.52. The carrier paid $128.53. No additional payment is recommended
- Procedure code 92507 billed June 8, 2018 has a PE of 0.87 not the highest for this date and will be paid at the reduced rate of $63.91. 58.31/35.9996 x $63.91 = $103.52. The carrier paid $128.53. No additional payment is recommended
- Procedure code 92507 billed June 15, 2018 has a PE of 0.87 not the highest for this date and will be paid at the reduced rate of $63.91. 58.31/35.9996 x $63.91 = $103.52. The carrier paid $128.53. No additional payment is recommended
- Procedure code 92507 billed June 20, 2018 has a PE of 0.87 not the highest for this date and will be paid at the reduced rate of $63.91. 58.31/35.9996 x $63.91 = $103.52. The carrier paid $128.53. No additional payment is recommended
- Procedure code 92507 billed June 21, 2018 has a PE of 0.87 not the highest for this date and will be paid at the reduced rate of $63.91. 58.31/35.9996 x $63.91 = $103.52. The carrier paid $128.53. No additional payment is recommended
- Procedure code 92507 billed June 29, 2018 has a PE of 0.87 not the highest for this date and will be paid at the reduced rate of $63.91. 58.31/35.9996 x $63.91 = $103.52. The carrier paid $128.53. No additional payment is recommended
- Procedure code 92507 billed June 25, 2018 has a PE of 0.87 not the highest for this date and will be paid at the reduced rate of $63.91. 58.31/35.9996 x $63.91 = $103.52. The carrier paid $128.53. No additional payment is recommended

4. The remaining code in dispute if 96152. This medical service provided in an outpatient setting is subject to provisions of 28 TAC §134.403 (f) which states in pertinent part,

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;

The carrier reduced the allowed amount as 4097 – "Paid per fee schedule; charge adjusted because statute dictates allowance is greater than provider's charge."

28 TAC 134.203 (e) (2) states in pertinent part,

> Regardless of billed amount, reimbursement shall be:
>
> (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.

The carriers' reduction is not supported the MAR is calculated as follows;

- Procedure code 96152, billed June 4, 2018, has status indicator Q3. As packaging criteria are not met, this line is separately paid. This line is assigned status indicator S, for procedures not subject to reduction. This code is assigned APC 5822. The OPPS Addendum A rate is $71.94, multiplied by 60% for an unadjusted labor amount of $43.16, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $41.59. The non-labor portion is 40% of the APC rate, or $28.78. The sum of the labor and non-labor portions is $70.37 multiplied by 4 units is $281.48. The Medicare facility specific amount of $281.48 is multiplied by 200% for a MAR of $562.96.
- Procedure code 96152, billed June 13, 2018, has status indicator Q3. As packaging criteria are not met, this line is separately paid. This line is assigned status indicator S, for procedures not subject to reduction. This code is assigned APC 5822. The OPPS Addendum A rate is $71.94, multiplied by 60% for an unadjusted labor amount of $43.16, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $41.59. The non-labor portion is 40% of the APC rate, or $28.78. The sum of the labor and non-labor portions is $70.37 multiplied by 4 units is $281.48. The Medicare facility specific amount of $281.48 is multiplied by 200% for a MAR of $562.96.
- Procedure code 96152, billed June 21, 2018, has status indicator Q3. As packaging criteria are not met, this line is separately paid. This line is assigned status indicator S, for procedures not subject to reduction. This code is assigned APC 5822. The OPPS Addendum A rate is $71.94, multiplied by 60% for an unadjusted labor amount of $43.16, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $41.59. The non-labor portion is 40% of the APC rate, or $28.78. The sum of the labor and non-labor portions is $70.37 multiplied by 4 units is $281.48. The Medicare facility specific amount of $281.48 is multiplied by 200% for a MAR of $562.96.

5. The total recommended reimbursement for the disputed services is $1,688.88. The insurance carrier paid $1,668.24. The requestor is seeking additional reimbursement of $6.45. 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 $6.45.

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 $6.45, 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 17, 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.