



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 DALLAS

Respondent Name

TWIN CITY FIRE INSURANCE COMPANY

MFDR Tracking Number

M4-19-3729-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

April 8, 2019

Response Submitted By

The Hartford

REQUESTOR'S POSITION SUMMARY

"Underpaid/denied APC."

RESPONDENT'S POSITION SUMMARY

"CPT code 96361 is an add-on code which requires an appropriate abas code be billed with it."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 23, 2018	Hospital Services: 71260, 96361, 96374, 96375	\$1,183.04	\$0.00

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 hospital facility fee guideline for outpatient services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
 - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
 - 1001 - BASED ON THE CORRECTED BILLING AND/OR ADDITIONAL INFORMATION/DOCUMENTATION NOW SUBMITTED BY THE PROVIDER, WE ARE RECOMMENDING FURTHER PAYMENT TO BE MADE FOR THE ABOVE NOTED PROCEDURE CODE.
 - 107 – CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT PREVIOUSLY PAID OR IDENTIFIED ON THIS CLAIM.
 - 292 – THIS PROCEDURE CODE IS ONLY REIMBURSED WHEN BILLED WITH THE APPROPRIATE INITIAL BASE CODE.
 - 906 – IN ACCORDANCE WITH CLINICAL BASED CODING EDITS (NATIONAL CORRECT CODING INITIATIVE/OUTPATIENT CODE EDITOR), COMPONENT CODE OF COMPREHENSIVE MEDICINE, EVALUATION AND MANAGEMENT SERVICES PROCEDURE (90000-99999) HAS BEEN DISALLOWED.
 - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
 - 4915 - THE CHARGE FOR THE SERVICES REPRESENTED BY THE REVENUE CODE ARE INCLUDED/BUNDLED INTO THE TOTAL FACILITY PAYMENT AND DO NOT WARRANT A SEPARATE PAYMENT OR THE PAYMENT STATUS INDICATOR DETERMINES THE SERVICE IS PACKAGED OR EXCLUDED FROM PAYMENT.
 - 18 – EXACT DUPLICATE CLAIM/SERVICE

- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 1115 - WE FIND THE ORIGINAL REVIEW TO BE ACCURATE AND ARE UNABLE TO RECOMMEND ANY ADDITIONAL ALLOWANCE
- 247 – A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards outpatient facility services 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 modified by DWC rules. Rule §134.403(f)(1) requires the Medicare facility amount be multiplied by 200% for these disputed facility services.

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.

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. 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 0.9756 for an adjusted labor amount of \$293.18. The non-labor portion is 40% of the APC rate, or \$200.34. The sum of the labor and non-labor portions is \$493.52. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of \$493.52 is multiplied by 200% for a MAR of \$987.04. The insurance carrier paid \$588.35 and \$398.69 for these two line-items, for a total of \$987.04 — which is the composite payment amount. No additional payment is due.
- Procedure code 96361 represents hydration infusion, each additional hour. The initial hour of hydration is billed with code 96360. The provider did not bill code 96360; therefore code 96361 is not supported. Based on the information presented for review the insurance carrier's denial reason is supported. Additional payment cannot be recommended.
- Per Medicare policy regarding correct coding (CCI edits), procedure codes 96374 and 96375 may not be reported with codes 74177 and 71260 billed on the same claim. Injection of a dye or contrast agent is included in the CT procedure with contrast. Separate payment may be justified if an appropriate modifier is used to distinguish separate services; however, the provider did not bill either code with a modifier. Separate payment is thus 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

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____	<u>Grayson Richardson</u>	<u>May 2, 2019</u>
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 DWCO45M) 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.