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
ZNAT Insurance Co

MFDR Tracking Number
M4-19-4398-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Code 64450 is not bundled… Code 96374 only paid billed charge and not fee schedule."

Amount in Dispute: 1,201.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After comprehensive review of the billed services, an additional $452.05 is due to the provider for the services in dispute."

Response Submitted by: Zenith

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 1, 2018	Outpatient Hospital Services	$1,201.86	$141.12

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 or denied the payment for the disputed services with the following claim adjustment codes:
   - 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guidelines
   - 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup

- 435 – Per NCCI edits the value of this procedure is included in the value of the comprehensive procedure

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 $1,201.86 for outpatient hospital services rendered on October 1, 2018. The insurance carrier reduced/denied the disputed services based on NCCI edits and packaging.

   28 TAC §134.403 (d) requires Texas workers' compensation system participants to apply Medicare payment policies in effect on the date of service when coding, billing, reporting and reimbursement.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators.

   The status indicator identifies whether the service described by the HCPCS code is paid under OPPS and if so, whether payment is made separately or packaged. The disputed Codes 64450 and 96374 are reviewed below.

2. 28 TAC §134.403, (f) 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.

Review of the submitted medical bill found separate reimbursement for implants was not requested. The maximum allowable reimbursement per the above is calculated as follows:

- Procedure code 64450 has status indicator T and is assigned APC 5442 however, review of the NCCI edits found at www.cms.gov found this procedure code has an edit with code 12002. No modifier was used to indicate a separate procedure. The insurance carrier's denial is supported.
- Procedure code 96374 is assigned APC 5693. The OPPS Addendum A rate is $191.09, multiplied by 60% for an unadjusted labor amount of $114.65, in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of $111.62. The non-labor portion is 40% of the APC rate, or $76.44. The sum of the labor and non-labor portions is $188.06. The Medicare facility specific amount of $188.06 is multiplied by 200% for a MAR of $376.12.

3. The total recommended reimbursement for the disputed services listed on the DWC060 is $376.12. The insurance carrier paid $235.00. The amount due is $141.12. This amount is recommended.

Conclusion

For the reasons stated above, DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $141.12.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
DWC hereby ORDERS the respondent to remit to the requestor $141.12, plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this order.

Authorized Signature

		October 3, 2019
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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.