



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

Doctors Hospital at Renaissance

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-17-3080-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

June 19, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: \$327.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Code 96374 is comprehended by code 26735 if an appropriate modifier is used. The bill fails to show a modifier was used. No payment is due. Texas Mutual will issue an additional payment of \$10.82 for code 26735."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 21, 2017	26735, 96374	\$327.78	\$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 adjustment codes:
 - P12 – Workers' compensation jurisdictional fee schedule adjustment
 - 767 – Paid per O/P at 200% Implants not applicable or separate reimbursement (with cert) not requested per Rule 134.403 (G)

- 236 – This billing code is not compatible with another billing code provided on the same day according to NCCI or Workers’ Compensation state regulations/fee schedule requirements
- 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure
- W3 – In accordance with TDI-DWC Rule 134.804. This bill has been identified as a request for reconsideration or appeal
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service

Issues

1. What is the applicable rule that applies to reimbursement?
2. Did the carrier make payment per applicable fee guideline?

Findings

1. The requestor is seeking \$327.78 for outpatient procedure rendered on February 21, 2017.

The insurance carrier denied Code 96374 with adjustment reason code 236 – “This billing code is not compatible with another billing code provided on the same day according to NCCI or Workers’ Compensation state regulations/fee schedule requirements” and 618 – “The value of this procedure is packaged into the payment of other services performed on the same date of service.”

The Division Rule that applies to Outpatient Hospital Services is found at 28 Texas Administrative Code §134.403. Section 134.403 (b) (3) and (d) states in pertinent part,

(b)(3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare

and

(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.

Review of the Medicare NCCI procedure to procedure (PTP) edits found at;

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html> finds an edit exists between Code 26735 and 96374. Therefore the carrier’s denial is supported. No additional payment is recommended.

2. The applicable sections of 28 Texas Administrative Code §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 finds separate reimbursement of implantable was not requested. The Maximum allowable reimbursement will be calculated per 28 Texas Administrative Code §134.403 (f)(1)(A).

Procedure Code	Status Indicator	APC	Payment Rate	60% labor related	2016 Wage Index Adjustment for provider 0.8026	40% non-labor related	Payment	Maximum allowable reimbursement
26735	J1	5113	\$2,438.34	\$2,438.34 x 60% = \$1,463.00	\$1,463.00 x 0.8026 = \$1,174.20	\$2,438.34 x 40% = \$975.34	\$1,174.20 + \$975.34 = \$2,149.54	\$2,149.54 x 200% = \$4,299.08
							Total	\$4,299.08

The total allowable for the service in dispute is \$4,299.08. The carrier paid a total of \$4,299.09. No additional reimbursement is 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

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

July 14, 2017
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.