



**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 Fort Worth

**Respondent Name**

Liberty Insurance Corp

**MFDR Tracking Number**

M4-15-2810-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

April 29, 2015

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We have found in this audit they have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule that started 3/01/2008 for the following account."

**Amount in Dispute:** \$1,305.72

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** Fax cover sheet dated Wednesday, May 20, 2015, with notes, "Response letter: M4-15-2810-01 WC949-C37931 (claimant) was submitted but no position statement was found.

**Response Submitted by:** Liberty Mutual

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 10, 2014	Outpatient Hospital Services	\$1,305.72	\$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 professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - X936 – CPT or HCPC is required to determine if services are payable
  - Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered.

- U634 – Procedure code not separately payable under Medicare and or fee schedule guidelines
- MV46 – Per CPT, Code appears to represent usual prep, intra or post procedure care and is not allowed separately. Service is included in 71260.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- W3 – Additional payment made on appeal/reconsideration
- P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

### Issues

1. What is the rule pertaining to the applicable Division fee guidelines?
2. Is the requestor entitled to additional reimbursement?

### Findings

1. 28 Texas Administrative Code §134.403 (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. 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.

(2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

The services in dispute will be calculated as follows:

- Procedure code 36415, date of service July 10, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 80048, date of service July 10, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 82565, date of service July 10, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 85025, date of service July 10, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 81001, date of service July 10, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 72125, date of service July 10, 2014, has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8006. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures

performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.

- Procedure code 74177, date of service July 10, 2014, has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPSS criteria are met, this service is assigned to composite APC 8006. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Procedure code 76376, date of service July 10, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 70450, date of service July 10, 2014, has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPSS criteria are met, this service is assigned to composite APC 8006. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Procedure code 71260, date of service July 10, 2014, has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPSS criteria are met, this service is assigned to composite APC 8006. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Per Medicare policy, procedure code 96374, date of service July 10, 2014, may not be reported with procedure code 99285 billed on the same claim. Payment for this service is included in the payment for the primary procedure. 28 Texas Administrative Code §134.403 (d) states, "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 with any additions or exceptions specified in this section,”  
Separate payment is not recommended.

- Per Medicare policy, procedure code 96375, date of service July 10, 2014, may not be reported with procedure code 99285 billed on the same claim. Payment for this service is included in the payment for the primary procedure. 28 Texas Administrative Code §134.403 (d) states, “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 with any additions or exceptions specified in this section,” Separate payment is not recommended.
- Procedure code 96376, date of service July 10, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 99285, date of service July 10, 2014, has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC if OPPS criteria are met; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. These services are classified under APC 0616, which, per OPPS Addendum A, has a payment rate of \$455.93. This amount multiplied by 60% yields an unadjusted labor-related amount of \$273.56. This amount multiplied by the annual wage index for this facility of 0.9549 yields an adjusted labor-related amount of \$261.22. The non-labor related portion is 40% of the APC rate or \$182.37. The sum of the labor and non-labor related amounts is \$443.59. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$443.59. This amount multiplied by 200% yields a MAR of \$887.18.
- Procedure code J2270, date of service July 10, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405, date of service July 10, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code Q9963, date of service July 10, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code Q9967, date of service July 10, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure codes 72125, 74177, 70450, and 71260, dates of service July 10, 2014, have a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8006, for computed tomography (CT) services including contrast. If a “without contrast” CT procedure is performed on the same date of service as a “with contrast” CT, APC 8006 is assigned rather than APC 8005. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. This line is assigned status indicator S, which denotes a significant procedure, not subject to multiple-

procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 8006, which, per OPPS Addendum A, has a payment rate of \$548.28. This amount multiplied by 60% yields an unadjusted labor-related amount of \$328.97. This amount multiplied by the annual wage index for this facility of 0.9549 yields an adjusted labor-related amount of \$314.13. The non-labor related portion is 40% of the APC rate or \$219.31. The sum of the labor and non-labor related amounts is \$533.44. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$533.44. This amount multiplied by 200% yields a MAR of \$1,066.88.

2. The total allowable reimbursement for the services in dispute is \$1,954.06. This amount less the amount previously paid by the insurance carrier of \$3,020.96. The carrier submitted a copy of an explanation of benefit that was illegible so only the amounts supported by a legible explanation of benefits were considered in this dispute. The amount due to the requestor is \$0.00. No additional reimbursement can be 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 upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

_____	_____	July 28, 2015
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 28 Texas Administrative Code §133.307, 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 with the Division. **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.**