



# 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**

Indemnity Insurance Co of North America

**MFDR Tracking Number**

M4-16-2652-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

May 3, 2016

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We show this HCPC has a Q1 status and should have processed for payment as not billed with any of the codes that would have bundled the x-rays."

**Amount in Dispute:** \$230.52

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Respondent paid a total of \$1,256.20 for the total outpatient hospital admission on 10/1/15. Payment was calculated according to the OPPS schedule allowance. Bundled procedures were not separately paid. No additional monies are owed to Requestor."

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 20, 2015	71001, 73030	\$230.52	\$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 claim adjustment codes:
  - W3 – Request for reconsideration
  - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
  - 97 – the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

## **Issues**

1. What is the Medicare payment rule?
2. Is the requestor entitled to additional reimbursement?

## **Findings**

1. The services in dispute are for Outpatient Hospital Services with dates of service August 20, 2015. 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...

The Medicare Claims Processing manual, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf>, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPSS), Section 10 defines the terms, Status Indicators, APC Payment Groups and Composite APCs as follows:

### **10.1.1 - Payment Status Indicators**

*An OPSS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPSS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPSS or under another payment system or fee schedule. For example, services with status indicator A are paid under a fee schedule or payment system other than the OPSS. Services with status indicator N are paid under the OPSS, but their payment is packaged into payment for a separately paid service. Services with status indicator T are paid separately under OPSS but a multiple procedure payment reduction applies when two or more services with a status indicator of T are billed on the same date of service.*

*The full list of status indicators and their definitions is published in Addendum D1 of the OPSS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPSS Addendum B.*

### **10.2 - APC Payment Groups**

*Each HCPCS code for which separate payment is made under the OPSS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. (See section 10.5 for discussion of multiple procedure discounting under the OPSS).*

#### **10.2.1 - Composite APCs**

*Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.*

Applicable CMS listing for the services in dispute is found at; <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates-Items/2015-July-Addendum-A.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending>

Review of the submitted medical claim finds the following:

Procedure Code	APC	Status Indicator
71101	0261	Q1 - STV-packaged services are services for which separate payment is made only if there is no service with status indicator S, T, V or reported with the same date of service on the same claim. If a claim includes a service that is assigned status indicator S, T, V reported on the same date of service as the STV- packaged service, the payment for the STV-packaged service is packaged into the payment for the service(s) with status indicator S, T, V and no separate payment is made for the STV-packaged service. STV-packaged services are assigned status indicator <b>Q1</b> .
73030	0261	Q1 - STV-packaged services are services for which separate payment is made only if there is no service with status indicator S, T, V or reported with the same date of service on the same claim. If a claim includes a service that is assigned status indicator S, T, V reported on the same date of service as the STV- packaged service, the payment for the STV-packaged service is packaged into the payment for the service(s) with status indicator S, T, V and no separate payment is made for the STV-packaged service. STV-packaged services are assigned status indicator <b>Q1</b> .
72125	0332	Q3 - Composite APC Status Indicator <b>S</b>
70450	0332	Q3 - Composite APC Status Indicator <b>S</b>
99284	0615	Q3 - Composite APC Status Indicator <b>V</b>

- Pursuant to the applicable Medicare payment policy, the services in dispute have a status indicator of Q1. As this claims contains services with a "S" and "V" status indicator, no additional payment 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 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 additional reimbursement for the services in dispute.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

May , 2016

### ***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.**