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 PRESBYTERIAN HOSPITAL ALLEN

Respondent Name
LIBERTY INSURANCE CORPORATION

MFDR Tracking Number
M4-18-3267-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 10, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review CPT code 76000 this code has status indicator of S and is paid under OPPS with a separate APC payment rate of $228.44 x 2% uplift."

Amount in Dispute: $447.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill has been reviewed and payment is issued correctly. Per CMS OPPS rate 2,290.83 @ 200% per TX FS = $4,581.66. CPT 7600 is a SI N and bundled to CPT 20680 (J1)."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 9, 2018	Outpatient Hospital Services	$447.45	$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

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 hospital facility fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - MX70 – PER NCCI, THE PROCEDURE CODE IS DENIED DUE TO MISUSE OF COLUMN 2 CODE WITH COLUMN 1 CODE. PROCEDURE INCLUDED IN 20680.
   - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.
   - 193 – CPT OR HCPCS IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
   - W3 – CPT OR HCPCS IS REQUIRED TO DETERMINE IF SERVICES

Issues

1. What is the recommended payment for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors, as published annually in the Federal Register, with modifications set forth in the rules. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   Rule §134.403(f)(1) requires the sum of the Medicare facility specific amount and any outlier payments be multiplied by 200 percent for the outpatient facility services in dispute.

   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 code J7120, J0690, J1100, J1170, J2250, J2405, J2704, J2710 and J3010 have status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
   - Per Medicare payment policy with regard to correct coding initiative (CCI) edits, procedure code 76000 may not be reported with code 20680 billed on the same claim. Reimbursement for this service is included with payment for the primary procedure. Separate payment is not recommended.
   - Procedure code 20680 has status indicator Q2, denoting T-packaged codes; reimbursement may be packaged with payment for any service with status indicator T on the claim. However, as no status T codes were billed, criteria for packaging are not met. This code is paid separately under APC 5073, which has a status indicator of J1, denoting packaged services paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure (except for certain limited exclusions that are not present on this claim). The OPPS Addendum A rate is $2,324.87, which is multiplied by 60% for an unadjusted labor-related amount of $1,394.92, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $1,360.88. The non-labor portion is 40% of the APC rate, or $929.95. The sum of the labor and non-labor portions is $2,290.83. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $2,290.83 is multiplied by 200% for a MAR of $4,581.66.

2. The total recommended reimbursement for the disputed services is $4,581.66. The insurance carrier has paid $4,581.67 leaving an amount due to the requestor of $0.00. Additional payment is not recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

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

	Grayson Richardson	June 1, 2018
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 DWC045M) in accordance with the form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.