TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH ALLIANCE

Respondent Name
LIBERTY INSURANCE CORPORATION

MFDR Tracking Number
M4-18-3789-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
June 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The correct allowable due is $6,000.66 less their previous payment of $1,605.89, which leaves an outstanding balance of $4,397.77."

Amount in Dispute: $4,397.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was reviewed and priced correctly …"

Response Submitted by: Liberty Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
June 9, 2017	Outpatient Hospital Services	$4,397.77	$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:
   - X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE.
   - MV46 – PER CPT, CODE APPEARS TO REPRESENT USUAL PREP, INTRA OR POST PROCEDURE CARE AND IS NOT ALLOWED SEPARATELY. SERVICE IS INCLUDED IN 71260.
   - Z652 - RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - P300 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
   - MOPS – SERVICES REDUCED TO THE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)
   - MSIN – THIS IS A PACKAGED ITEM. SERVICES OR PROCEDURES INCLUDED IN THE APC RATE, BUT NOT PAID SEPARATELY
   - MV01 – PER CPT, CODE IS DENIED BASED ON CPT INSTRUCTIONS. SERVICE INCLUDED IN 80053.
   - MP86 – RECOMMENDED REIMBURSEMENT IS BASED ON CMS HOSPITAL OUTPATIENT COMPOSITE APC 8006.
   - 193 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)

- W3 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES
- B13 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.

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 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 applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors, as published annually in the Federal Register, with modifications set out in the rules. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200 percent for the disputed emergency room services.

   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 codes 36415, 82565, 80053 and 85025 have status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 99284 has status indicator J2, denoting outpatient visits. This code is assigned APC 5024. The OPPS Addendum A rate is $332.41. This is multiplied by 60% for an unadjusted labor-related amount of $199.45, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $191.83. The non-labor portion is 40% of the APC rate, or $132.96. The sum of the labor and non-labor portions is $324.79. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $324.79 is multiplied by 200% for a MAR of $649.58.
   - Per Medicare policy regarding correct coding (CCI) edits, procedure code 96375 may not be reported with code 71260 billed on the same claim. Reimbursement for this code is included with payment for the primary service.
   - Per Medicare policy regarding CCI edits, procedure code 96374 may not be reported with codes 74177 or 71260 billed on the same claim. Reimbursement for this code is included with payment for the primary services.
   - Procedure codes J2930 and J1200 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.
   - Procedure codes 74177, 72131, 72128, 72125, 70450, and 71260 have status indicator Q3, denoting packaged codes paid through a composite APC. Codes assigned to composites are major components of a single episode of care; the hospital receives one payment for any combination of designated procedures. These services are assigned composite APC 8006—computed tomography (CT) services including contrast. If a "without contrast" CT and a "with contrast" CT are billed together, APC 8006 is assigned instead of APC 8005. If a composite includes multiple lines, the charges for those combined services are summed to one line. To determine outliers, a single cost for the composite is estimated from the summarized charges. Total packaged cost is allocated to the composite line in proportion to other separately paid services on the bill. This line is assigned status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. The OPPS Addendum A rate for APC 8006 is $489.37. This is multiplied by 60% for an unadjusted labor amount of $293.62, in turn multiplied by the facility wage index of 0.9618 for an adjusted labor amount of $282.40. The non-labor portion is 40% of the APC rate, or $195.75. The sum of the labor and non-labor portions is $478.15. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $478.15 is multiplied by 200% for a MAR of $956.30.
2. The total recommended reimbursement for the disputed services is $1,605.88. The insurance carrier paid $1,605.89. 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 22, 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.