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 OF PLANO

Respondent Name
STATE AUTOMOBILE MUTUAL INSURANCE

MFDR Tracking Number
M4-18-4482-01

Carrier's Austin Representative
Box Number 16

MFDR Date Received
July 26, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HCPCS's are payable at 200% of the correct fee schedule allowable. Please note per the NCCI Edits this line is not bundled and we show should have processed for payment as there are no S, T or V status indicators used for the codes to be bundled into."

Amount in Dispute: $222.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "If more than one Q1 or Q2 code is reported, and no code is reported that riggers packaging, payment is made for the highest paying Q1 or Q2 code and all other Q1 and Q2 codes are packaged."

Response Submitted by: Aetna/Coventry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 16, 2017 to November 17, 2017	Outpatient Hospital Services: 72070	$222.67	$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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - MSIN – In accordance with CMS guidelines, This is a packaged service and is not paid separately. However, charges related to this service is used to pay other payable services and qualify those services for outlier.
   - MOPS – services reduced to the Outpatient Prospective Payment System (OPPS).
   - W3 – Request for reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards outpatient facility services subject to DWC's *Hospital Facility Fee Guideline*, Rule §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 published in the Federal Register, as modified by DWC rules. Medicare assigns an Ambulatory Payment Classification (APC) to OPPS services based on billed procedure codes and supporting documentation. The APC determines the payment rate. Payment for ancillary items and services is packaged. CMS publishes quarterly APC rate updates, available at www.cms.gov.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 72070 has status indicator Q1, for STV-packaged codes; reimbursement for this service is packaged with payment for service code 72100, which also has status indicator Q1, billed for the same date.

  Per Medicare payment policy, where a bill contains multiple STV-packaged Q1 status codes (and does not contain a procedure with status indicator S, T, or V), separate payment is made for the STV-packaged code assigned the highest paid APC. Payment for all other Q1 codes is packaged into the payment for the highest paid STV-packaged code. See *Medicare Claims Processing Manual* Chapter 4, §10.4.1 for further details on Medicare policies regarding combinations of packaged services furnished on the same medical bill.

  Only a single Q1 status code (the Q1 code with the highest APC payment) may be paid per bill. In this case, both Q1 codes have the same APC payment. The insurance carrier paid Q1 status code 72100, packaging the reimbursement for code 72070 with the payment for code 72100 in accordance with Medicare policy.

Consequently, the requestor is not entitled to additional reimbursement.

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

	Grayson Richardson	October 12, 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 division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 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.