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 DALLAS

Respondent Name
WEST AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-18-5059-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
August 20, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT 71260 has a status indicator of Q3 with a composite rate of 8006 . . . CPT 71010 has a status indicator of Q3 with APC 5521 which pays per CMS Addendum B and is separately payable."

Amount in Dispute: $1,084.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please note CPT 71010 and CPT 71260 were billed . . . along with a J2 code and observation service with more than 8 UOS billed therefore all codes billed . . . would be packaged and allowed to APC 8011. Based on the state fee schedule rules . . . no further payment is due, for either code as billed as they are considered packaged items."

Response Submitted by: Aetna

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 11, 2017 to September 12, 2017	Outpatient Hospital Services: 71010, 71260	$1,084.42	$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.

   With additional payment advice:
   - Recommended reimbursement is based on CMS Hospital Outpatient Composite for Comprehensive Observation Services.
   - Services reduced to the Outpatient Prospective Payment System (OPPS).
   - The amount paid reflects a fee schedule reduction.
   - G - Recommendation of payment has been based on this procedure code, 71010, which best describes services rendered.
   - K - Recommendation of payment has been based on this procedure code, 71260, which best describes services rendered.

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 published 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 these disputed outpatient facility 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 code 99285 has status indicator J2, for outpatient visits subject to comprehensive packaging criteria are met. This procedure code was billed in combination with code G0378 with 21 units, indicating more than 8 hours of observation. Review of the submitted documentation finds that the criteria for comprehensive packaging is supported. Payment for codes 71010 and 71260 is included within the reimbursement for the comprehensive observation services. These services are assigned APC 8011. The OPPS Addendum A rate is $2,222.64, multiplied by 60% for an unadjusted labor amount of $1,333.58, in turn multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $1,306.11. The non-labor portion is 40% of the APC rate, or $889.06. The sum of the labor and non-labor portions is $2,195.17. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $2,195.17 is multiplied by 200% for a MAR of $4,390.34.
   - Payment for all other services on the bill — including disputed diagnostic tomography codes 71010 and 71260 — is packaged with the primary comprehensive J2 service according to Medicare policy regarding comprehensive APCs. Reimbursement for all items is included in the payment for the primary procedure. Please see *Medicare Claims Processing Manual* Chapter 4, §10.2.3 and §290.5.3 for further details.

2. The disputed service codes, 71010 and 71260, were packaged with J2 status code 99285 and paid comprehensively under APC 8011 for Comprehensive Observation Services. Codes 71010 and 71260 are not separately paid when Medicare comprehensive payment criteria are met. The total recommended payment for the comprehensive services was $4,390.34. The insurance carrier paid $4,390.34 for the comprehensive service, leaving an amount due to the requestor of $0.00. No additional payment is 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 evidence presented by the requestor and respondent available 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	September 7, 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.