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 AZLE

Respondent Name
ZURICH AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-19-0106-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 7, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/denied APC."

Amount in Dispute: $1,569.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "With respect to CPT code 71260, the recommended reimbursement is based on CMS Hospital Outpatient Composite APC8006. The carrier reimbursed the provider for other services in the amount of $1,998.76. . . . With respect to CPT code 96361, the benefit for this service was included in the payment/allowance for another service/procedure. . . . With respect to CPT codes 96374 and 96375, the benefit was included in the payment/allowance for another service/procedure."

Response Submitted by: Flahive, Odgen & Latson, Attorneys at Law, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
June 22, 2018	Outpatient Hospital: 71260, 96361, 96374, 96375	$1,569.79	$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:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - Z652 - Recommendation of payment is based on a procedure code that best describes services rendered.
   - P300 – The amount paid represents a fee schedule reduction.
   - MP86 – Recommended reimbursement is based on CMS hospital outpatient composite APC 8006.
   - W3 – Request for reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

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 emergency room 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. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for the 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 all billed services is calculated as follows. Although the requestor is only disputing the payment for 4 codes (**71260**, **96361**, **96374**, and **96375**), because payment for those services is packaged or excluded in relation to other services on the bill, the payment calculations for the entire bill are shown below:

   - Procedure codes 90715, J7030, J1885, Q0162, Q9967 and Q9967 have status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
   - Procedure codes 36415, 80053, 82550, 82550, 84484 and 85025 have status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
   - Procedure codes 73030, 73140, 73610, 12002, 93005 and 90471 have status indicator Q1, for STV-packaged codes; If Q1 status STV-packaged codes are billed with any services paid as a composite, the Q1 status codes are packaged into the composite payment. Reimbursement for these services is included in the composite payment for APC 8006 (CT scans with contrast) below. See *Medicare Claims Processing Manual* Chapter 4, §10.4.1 for further information about CMS policies regarding packaged services.

   ➢ Procedure codes 72125, 74177, 70450, and **71260** have status indicator Q3, for 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, for 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, for procedures not subject to reduction. This code is assigned APC 8006. The OPPS Addendum A rate is $500.85, multiplied by 60% for an unadjusted labor amount of $300.51, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $289.57. The non-labor portion is 40% of the APC rate, or $200.34. The cost of services does not exceed the threshold for outlier payment. The sum of the labor and non-labor portions is the Medicare facility specific amount of $489.91. This is multiplied by 200% for a MAR of $979.82.

   ➢ Per Medicare policy regarding correct coding (CCI) edits, procedure code **96361** may not be reported with code 12002 on the same bill. Reimbursement is included with payment for the primary procedure. Separate payment is not recommended.

   ➢ Per Medicare policy regarding correct coding (CCI) edits, procedure code **96374** may not be reported with codes 12002, 71260 and 74177 on the same bill. Reimbursement for this service is included with payment for the primary procedures. Separate payment is not recommended.

   ➢ Per Medicare policy regarding correct coding (CCI) edits, procedure code **96375** may not be reported with codes 12002 and 71260 on the same bill. Reimbursement for this service is included with payment for the primary procedures. Separate payment is not recommended.

- Per Medicare policy, procedure code 99285 represents outpatient evaluation and management services. This code is assigned APC 5025. The OPPS Addendum A rate is $520.85, multiplied by 60% for an unadjusted labor amount of $312.51, in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $301.13. The non-labor portion is 40% of the APC rate, or $208.34. The cost of services does not exceed the threshold for outlier payment. The sum of the labor and non-labor portions is the Medicare facility specific amount of $509.47. This is multiplied by 200% for a MAR of $1,018.94.

2. The total recommended reimbursement for the bill is $1,998.76. The insurance carrier paid $1,998.76. 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 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	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.