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 PLANO

Respondent Name
FARMINGTON CASUALTY COMPANY

MFDR Tracking Number
M4-19-1195-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
November 1, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPTs 71045, 70450 and 96374 … are incorrectly denying for bundling as this CCI conflict is overridden by CPT 99285 billed with a 25 modifier making it separate and distinct."

Amount in Dispute: $1,430.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the Provider was properly reimbursed."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 28, 2018 to March 1, 2018	Outpatient Hospital Services	$1,430.05	$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 – PAYMENT ADJUSTED BECAUSE 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.
   - 4915 - THE CHARGE FOR THE SERVICES REPRESENTED BY THE REVENUE CODE ARE INCLUDED/BUNDLED INTO THE TOTAL FACILITY PAYMENT AND DO NOT WARRANT A SEPARATE PAYMENT OR THE PAYMENT STATUS INDICATOR DETERMINES THE SERVICE IS PACKAGED OR EXCLUDED FROM PAYMENT.
   - 4097 - PAID PER FEE SCHEDULE; CHARGE ADJUSTED BECAUSE STATUTE DICTATES ALLOWANCE IS GREATER THAN PROVIDER'S CHARGE.
   - 56 – SIGNIFICANT, SEPARATELY IDENTIFIABLE E/M SERVICE RENDERED
   - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- 1115 - We find the original review to be accurate and are unable to recommend any additional allowance
- 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
- 1001 - Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 1014 - The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

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 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 these disputed 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.

The requestor asserts, "this CCI conflict is overridden by CPT 99285 billed with a 25 modifier making it separate…"

Firstly, Medicare policy regarding CCI edits allows additional payment if an appropriate modifier is used to distinguish separate services and is supported by the medical record. However, the modifier must be appended to the code for which the provider is seeking separate payment — not to the conflicting code listed in the edit.

Secondly, while modifiers may override CCI edits, modifiers do not override Medicare packaging policies regarding single payment for composite services with status indicator Q3, or for services packaged comprehensively under a primary service with status indicator J1.

Lastly, when a bill has a code with status indicator J2, if criteria are met, Medicare packages payment for all other services on the bill into the reimbursement for Comprehensive Observation Services, APC 8011.

Criteria for packaging of Comprehensive Observation Services (APC 8011) include:

1) presence of an evaluation/visit code with status indicator J2;
2) 8 or more hours of observation billed under code G0378;
3) No other codes with status indicators T or J1 present on the bill; and
4) medical documentation of physician care and assessment of risk.

Codes packaged as part of a composite (Q3), comprehensive service (J1), or comprehensive observation services (J2) are not separately paid — even if a modifier is appended. Only ambulance, mammography, certain preventive services and codes with status indicators U, G, H, F or L are excluded from comprehensive APC packaging.

Please see *Medicare Claims Processing Manual* Chapter 4, §290.5.3 regarding billing and payment for observation services and §10.2.3 regarding Comprehensive APCs for further information on these Medicare payment policies.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 99285 has status indicator J2, for outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed). The provider billed 38 hours observation. Medicare packaging criteria are met; therefore, the entire bill is paid at a comprehensive rate under APC 8011. The OPPS Addendum A rate is $2,349.82, multiplied by 60% for an unadjusted labor amount of $1,409.89, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $1,375.49. The non-labor portion is 40% of the APC rate, or $939.93. 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 $2,315.42. This is multiplied by 200% for a MAR of $4,630.84.

- Reimbursement for all other items on the bill is packaged with payment for the primary comprehensive J2 service, code 99285. See *Medicare Claims Processing Manual* Chapter 4 §10.2.3 for details regarding this policy.

The total recommended reimbursement for the disputed services is $4,630.84. The insurance carrier paid $7,000.98. 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 emphasizes that the findings in this decision 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	November 30, 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.