



# 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 SOUTHWEST

**Respondent Name**

EMPLOYERS PREFERRED INSURANCE COMPANY

**MFDR Tracking Number**

M4-18-3994-01

**Carrier's Austin Representative**

Box Number 04

**MFDR Date Received**

June 13, 2018

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "there still remains a balance due for the TDI allowable for 73110 for underpay of 83.55."

**Amount in Dispute:** \$83.55

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "CPT 73110 has a Medicare status indicator of Q1 and a relative value of 0. This is considered a packaged service and not entitled to separate [sic] reimbursement."

**Response Submitted by:** Conduent

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
June 13, 2017	Outpatient Hospital Services	\$83.55	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 56 – SIGNIFICANT, SEPARATELY IDENTIFIABLE E/M SERVICE RENDERED
  - 86 – SERVICE PERFORMED WAS DISTINCT OR INDEPENDENT FORM OTHER SERVICES PERFORMED ON THE SAME DAY.
  - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
  - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
  - 954 – THE ALLOWANCE FOR NORMALLY PACKAGED REVENUE AND/OR SERVICE CODES HAVE BEEN PAID IN ACCORDANCE WITH THE DISPERSED OUTPATIENT ALLOWANCE.
  - B20 – PAYMENT ADJUSTED BECAUSE PROCEDURE/SERVICE WAS PARTIALLY OR FULLY FURNISHED BY ANOTHER PROVIDER.
  - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
  - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

- 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.
- 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.
- 5280 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION

### **Issues**

1. What is the recommended payment for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

### **Findings**

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.

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 visit 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](http://www.cms.gov).

Reimbursement for the disputed services is calculated as follows:

- Procedure code 73110 has status indicator Q1, denoting STV-packaged codes; reimbursement is included with payment for procedure codes 24640, 96374 and 96375 (which have status indicators of T and S) billed on the same date. A modifier is not allowed. Separate payment is not recommended.
  - Procedure code 24640 has status indicator T, denoting procedures subject to multiple-procedure reduction. This code is assigned APC 5111. The OPPS Addendum A rate is \$199.83. This is multiplied by 60% for an unadjusted labor amount of \$119.90, which is multiplied by the facility wage index of 0.9618 for an adjusted labor amount of \$115.32. The non-labor portion is 40% of the APC rate, or \$79.93. The sum of the labor and non-labor portions is \$195.25. This amount is multiplied by 200% for a MAR of \$390.50.
  - 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 amount of \$199.45, which is 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. This amount is multiplied by 200% for a MAR of \$649.58.
  - Procedure code 96374 has status indicator S, denoting procedures paid by APC, not subject to reduction. This code is assigned APC 5693. The OPPS Addendum A rate is \$179.77. This is multiplied by 60% for an unadjusted labor amount of \$107.86, which is multiplied by the facility wage index of 0.9618 for an adjusted labor amount of \$103.74. The non-labor portion is 40% of the APC rate, or \$71.91. The sum of the labor and non-labor portions is \$175.65. This amount is multiplied by 200% for a MAR of \$351.30.
  - Procedure code 96375 has status indicator S, denoting procedures paid by APC, not subject to reduction. This code is assigned APC 5691. The OPPS Addendum A rate is \$34.78. This is multiplied by 60% for an unadjusted labor amount of \$20.87, which is multiplied by the facility wage index of 0.9618 for an adjusted labor amount of \$20.07. The non-labor portion is 40% of the APC rate, or \$13.91. The sum of the labor and non-labor portions is \$33.98. This amount is multiplied by 200% for a MAR of \$67.96.
  - Procedure code 99152, J2405 and J2270 have status indicator N, denoting packaged codes with no separate payment; reimbursement is included with payment for the primary services.
2. The total recommended reimbursement for the disputed services is \$1,459.34. The insurance carrier paid \$1,611.94. 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	July 13, 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.