



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 SPINE AND JOINT HOSPITAL

Respondent Name

LIBERTY MUTUAL FIRE INSURANCE

MFDR Tracking Number

M4-16-3221-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

June 21, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This authorization covered the sacroiliac intra-articular injection . . . The Hospital billed Liberty Mutual, but the bill was denied. . . the reconsideration was denied due to coding / billing errors. . . our position is that the bill is coded correctly."

Amount in Dispute: \$8,155.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The original bill contained the code for use by ASC's but this is billed as outpatient hospital so it was not payable."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: June 22, 2015, Outpatient Hospital Facility Services, \$8,155.00, \$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 acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- MNSR – REVENUE CODES AND OTHER PACKAGED PROCEDURES ARE NOT SEPARATELY REIMBURSABLE AND ARE TO BE PACKAGED INTO OTHER SERVICES WHEN BILLED ON AN OUTPATIENT BASIS.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

- Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
- ESIB – ACCORDING TO CMS RULES, STATUS INDICATOR B CODES ARE NOT PAYABLE ON OPPS. (ESIB)

Issues

1. Are the insurance carrier’s denial reasons supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied payment for procedure code 27096 with reason code ESIB – “ACCORDING TO CMS RULES, STATUS INDICATOR B CODES ARE NOT PAYABLE ON OPPS. (ESIB).”

Per Medicare payment policy, procedure code 27096 has a status indicator B which indicates codes that are not recognized by Medicare when submitted on an outpatient hospital bill.

The requestor did not present documentation of Medicare policies to support their position that the service is payable as billed.

The insurance carrier’s denial reason is supported.

2. This dispute regards outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure codes billed and supporting documentation. A payment rate is established for each APC. Hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services (including services billed without procedure codes) is packaged into the payment for each APC. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available from the Centers for Medicare and Medicaid Services (CMS). Reimbursement for the disputed services is calculated as follows:

- Procedure code J3010 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services.
- Procedure code J2250 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services.
- Procedure code J1030 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services.
- Procedure code J7030 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services.

- Per Medicare’s correct coding initiative (CCI) payment policy, procedure code 96365 may not be reported with procedure code 27096 billed on this same date. Reimbursement for this procedure is packaged into procedure code 27096. Separate payment is not recommended.
- Procedure code Q9967 has status indicator N denoting packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services.
- Procedure code 27096 has status indicator B denoting codes that are not recognized by OPSS when submitted on an outpatient hospital bill. Reimbursement is not recommended.

4. The total recommended payment for the services in dispute is \$0.00.

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 documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	July 28, 2016
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 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

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 instructions on the form. 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 listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution 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.