TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEMORIAL HERMANN HOSPITAL

Respondent Name
LIBERTY INSURANCE CORPORATION

MFDR Tracking Number
M4-19-3092-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
February 11, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please see the attached itemized bill which shows the line items were coded correctly for Texas."

Amount in Dispute: $6,304.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "per OPPS – 27096 is listed as a Status B, therefore not payable."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 26, 2018	Outpatient Hospital Services	$6,304.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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:
   - 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.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 797 – SERVICE NOT PAID UNDER MEDICARE OPPS.
   - X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
   - Z652 - RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.
   - ESIB – ACCORDING TO CMS RULES, STATUS INDICATOR B CODES ARE NOT PAYABLE IN AN OUTPATIENT SETTING.

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 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 facility services.

Reimbursement for the disputed services is calculated as follows:

- Procedure codes J0702, J2001, J2250, J2704, and Q9967 are incidental service codes with status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the total service package.
- Procedure code 27096 has status indicator B, for codes not payable as an outpatient service—this code should not be used on an outpatient hospital bill (type 12x and 13x). Payment is not recommended.

The requestor did not bill any procedure codes that are reimbursable under the Medicare Outpatient Prospective Payment System or division rules. The requestor provided insufficient information to support that payment is due for the disputed services. Consequently, payment cannot be 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	March 15, 2019
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.