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 FORT WORTH

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-20-0098-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
September 13, 2019

Response Submitted By
Liberty Mutual Insurance

REQUESTOR'S POSITION SUMMARY

"We understand that code 27724 is to be billed as inpatient, however our facility was able to safely perform the procedure in the more cost effective inpatient [sic] setting. The patient did not require an inpatient stay. We feel that we should still be reimbursed accordingly at a fair and reasonable rate."

RESPONDENT'S POSITION SUMMARY

"CPT 27724 is found to have Status Indicator C which shows CPT is not paid under OPPS and this treatment should have been handled as inpatient."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 17, 2018	Outpatient Hospital Services	$10,701.75	$0.00

AUTHORITY

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 (DWC).

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:
   - 798 – SERVICE IS ONLY REIMBURSED ON AN INPATIENT BASIS.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

Are the insurance carrier's reasons for denial of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code 798 – "Service is only reimbursed on an inpatient basis."

28 Texas Administrative Code §134.403(d) requires that for coding, billing, reporting, and reimbursement of covered health care, system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in DWC rules.

Rule 28 TAC §134.403(d)(3) further requires that "Whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on and after the effective date…"

The disputed service is procedure code 27724, which has payment status indicator C, for inpatient procedures not payable under OPPS in an outpatient setting.

The requestor asserts, "our facility was able to safely perform the procedure in the more cost effective inpatient [sic] setting. The patient did not require an inpatient stay. We feel that we should still be reimbursed accordingly at a fair and reasonable rate."

As explained in *Medicare Claims Processing Manual* Chapter 4, §180.7:

> services designated to be "inpatient only" services are not appropriate to be furnished in a hospital outpatient department. "Inpatient only" services are generally, but not always, surgical services that require inpatient care because of the nature of the procedure, the typical underlying physical condition of patients who require the service, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged.
>
> There is no payment under the OPPS for services that CMS designates to be "inpatient-only" services. These services have an OPPS status indicator of "C" in the OPPS Addendum B and are listed together in Addendum E of each year's OPPS/ASC final rule. For the most current Addendum B and for Addendum E published with the OPPS notices and regulations, see http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.
>
> CMS does not pay for an "inpatient-only" service furnished to a person who is registered in the hospital as an outpatient and reports the service on the outpatient hospital bill type (TOB 13X).

DWC's *Hospital Facility Fee Guideline*, Rules 28 TAC §§ 134.403 (i) and (j) make special provision for performing such inpatient procedures in an outpatient setting if the health care provider and insurance carrier agree beforehand.

28 TAC § 134.403(i) states, "Notwithstanding Medicare payment policies, whenever Medicare requires a specific setting for a service, that restriction shall apply, unless an alternative setting and payment has been approved through the Division's preauthorization, concurrent review, or voluntary certification of health care process."

28 TAC § 134.403(i) further states:

> A preauthorization request may be submitted for an alternative facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request. Copies of the agreement shall be kept by both parties…."
>
> (1) The agreement between the insurance carrier and the party that requested the alternative facility setting must be in writing, in clearly stated terms, and include:
> (A) the reimbursement amount;
> (B) a description of the services to be performed under the agreement;
> (C) any other provisions of the agreement; and
> (D) names of the entities, titles, and signatures of both parties, and names, titles, signatures with dates of the persons signing the agreement.
>
> (2) An agreement for an alternative facility setting may be revised during or after preauthorization by written agreement of the insurance carrier and the party that requested the alternative facility setting.

Review of the submitted information finds no preauthorization approval to perform the disputed service in an outpatient setting, nor evidence of a signed agreement establishing the reimbursement price.

The requestor did not meet the requirements of Rules 28 TAC §§ 134.403 (i) and (j) for performing this procedure in an outpatient facility setting; The insurance carrier's denial reasons are therefore supported. Consequently, 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 findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the requestor has not established that additional payment is due. As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	October 11, 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 28 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.