



# 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 Mutual Fire Insurance Co

**MFDR Tracking Number**

M4-18-5011-01

**Carrier's Austin Representative**

Box Number 1

**MFDR Date Received**

August 13, 2018

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

**Amount in Dispute:** \$1,624.47

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The bill for DOS 02/27/18 has been reviewed and no additional payment is due as per billing practices, the provider has not billed with the correct CPT for reimbursement."

**Response Submitted by:** Liberty Mutual Insurance

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 27, 2018	G0390	\$1,624.47	\$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 reimbursement guidelines for outpatient hospital claims.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered
  - X901 – Documentation does not support level of service billed

**Issues**

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?

**Findings**

1. The requestor is seeking reimbursement for Code G0390 for date of service, February 27, 2018. The carrier denied as X901 – “Documentation does not support level of service billed.”

28 Texas Administrative Code §134.403 (d) states,

For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

Review of the Medicare Claims Processing Manual at [www.cms.gov](http://www.cms.gov), Chapter 4, Section 160.1 finds,

*Under the OPPS, the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient. If the physician and hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can only be counted once.*

*Beginning in CY 2007 hospitals may continue to report a charge with RC 68x without any HCPCS code when trauma team activation occurs. In order to receive additional payment when critical care services are associated with trauma activation, the hospital must report G0390 on the same date of service as RC 68x, in addition to CPT code 99291 (or 99292, if appropriate).*

The submitted medical bill found code 99291 was not submitted. The carrier’s denial is supported. No additional payment is recommended.

**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 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**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

September 19, 2018

\_\_\_\_\_  
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, 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. **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.**