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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Allegis Revenue Group

Respondent Name
The Insurance Company

MFDR Tracking Number
M4-13-1094-01

Carrier's Austin Representative
Box Number 09

MFDR Date Received
January 3, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached billing was denied based upon a lack of preauthorization. Under normal circumstances the utilization review process established the medical necessity of a treatment before the service is rendered. As these services were not subjected to a prior medical necessity review, we ask that you evaluate the treatment in question pursuant to 28 Tex. Admin. Code §19.2015."

Amount in Dispute: $23,654.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 28, – April 3, 2012	Inpatient Hospital Services	$23,654.23	$23.654.23

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 182 – Reviewed as No Charge
   - 197 – Payment adjusted for absence of precert/preauth
   - B13 – Payment for service may have been previously paid

Issues

1. Did the services in dispute require pre-authorization?
2. Were the disputed services subject to a specific fee schedule set in a contract between the parties that

complies with the requirements of Labor Code §413.011?

3. Which reimbursement calculation applies to the services in dispute?
4. What is the maximum allowable reimbursement for the services in dispute?
5. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The insurance carrier denied disputed surgical services billed under DRG 857 with reason code 197 – "Payment adjusted for absence of precert/preauth " Per 28 Texas Administrative Code §134.600(c)(1), (c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title." 28 Texas Administrative Code §133.2(5) Defines an Emergency as, "(5) Emergency--Either a medical or mental health emergency as follows:
   (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:
   (i) placing the patient's health or bodily functions in serious jeopardy, or
   (ii) serious dysfunction of any body organ or part; Documentation was found to support a medical emergency.

   Specifically; Surgical documentation states, "presents to our office today with obvious drainage from his wound with a very suspect looking wound." The insurance carrier's denial reason is not supported. Therefore the services in dispute will be reviewed per applicable fees and guidelines.

2. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

3. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 143 percent; unless
   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
   No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).

4. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Documentation found supports that the DRG assigned to the services in dispute is 857, and that the services were provided at University medical Center at Brackenridge. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $16.541.42. This amount multiplied by 143% results in a MAR of $23,654.23.

5. The division concludes that the total allowable reimbursement for the services in dispute is $23,654.32. The respondent issued payment in the amount of $0.00. Based upon the documentation submitted, additional reimbursement in the amount of $23,654.32 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $23,654.32 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		May 7, 2014
Signature	Medical Fee Dispute Resolution Officer	Date
		May 7, 2014
Signature	Medical Fee Dispute Resolution Manager	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 MDR 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.