



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

J. A, McNally MD

Respondent Name

Texas Mutual

MFDR Tracking Number

M4-14-3678-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

August 18, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...Patient returned to have sutures removed and had adverse reaction."

Amount in Dispute: \$1,288.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its position the rationale for general anesthesia to remove stitches does not meet the definition for life threatening emergency at Rule 133.2. Thus, preauthorization was required but not obtained.."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 12, 2013	01810, 99140	\$1,288.45	\$267.17

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.2 defines an emergency.
- 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
- 28 Texas Administrative Code §134.203 sets our reimbursement guidelines for professional services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Precertification/authorization/notification absent
 - 284 – No allowance was recommended as this procedure has Medicare status of "B" bundled
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Does the disputed service(s) meet the exemption of prior authorization?
2. What is the rule that determines reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason code, 197 – “Precertification/ authorization/notification absent. 28 Texas Administrative Code §133.2(4)(A) states that, “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 function in serious jeopardy, or (ii) serious dysfunction of any body organ or part.” The medical documentation does meet the definition of an emergency pursuant to §133.2(4)(A). For example:
 - a. “Attempt at removal of stitches postoperatively failed. The patient had panic attack and vasovagal reaction....”

28 Texas Administrative Code §134.600 (c) states in pertinent part, “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 (relating to General Medical Provisions).

The Division finds exemption to prior authorization is met. Therefore, the disputed services will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.203 (c) states in pertinent part, “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor). For Surgery when performed in a facility setting, the established conversion factor to be applied is (date of service yearly conversion factor). The maximum allowable reimbursement will be calculated as follows;

Submitted Code	Base Unit Code	Calculation of Anesthesia time units	Location Conversion Factor (Dallas)	Base and time units multiplied by anesthesia conversion factor specific to locality	TDI-DWC Conversion Factor / Medicare Conversion Factor x Facility Price = MAR
01180	3	$45 \div 15 = 3$	21.82	$3 + 3 = 6 \times 21.82 = \130.92	$(69.43/34.023) \times 130.92 = \267.17

The submitted code 99140 has a status code of “B” which is considered bundled. No additional payment can be recommended.

3. The total recommended payment for the services in dispute is \$267.17. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$267.17. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$267.17.

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 \$267.17 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

January , 2015
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.