



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

St Joseph Regional Health Center

Respondent Name

Texas Mutual Insurance

MFDR Tracking Number

M4-15-1924-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

February 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Her trip to the ER after the second fall was reasonable and necessary with the recent hip fracture only eight weeks old and no surgical fixation had been done to secure the fracture site."

Amount in Dispute: \$1,432.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the documentation from St Joseph Regional Health Center does not meet the criteria of the above definition."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 14, 2014	Emergency Room Services	\$1,432.00	\$425.60

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 emergency.
- 28 Texas Administrative Code §134.403 sets out reimbursement guidelines for outpatient hospital services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 899 – Documentation and file review does not support an emergency in accordance with Rule 133.2
 - 193 – Original payment decision is being maintained

Issues

- Did the requestor support the definition of emergency met?
- What is the applicable rule pertaining to reimbursement?
- Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.2 (5) an emergency is defined as, “(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;” Review of the medical record finds;
 - Triage Notes: Pt states fell today and re-injured right hip. Pt reports falling and breaking right hip in January

The Division finds as the onset of pain was sudden as a result of a fall and the reasonable expectation of the re-injury to the previously fractured hip requiring immediate medical attention was met. The Carrier’s denial is not supported. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.

2. Per 28 Texas Administrative Code §134.403 (f) 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 Outpatient Prospective Payment System (OPPS) 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) 200 percent;” The maximum allowable reimbursement calculations are as follows;
 - Procedure code 73510 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$57.35. This amount multiplied by 60% yields an unadjusted labor-related amount of \$34.41. This amount multiplied by the annual wage index for this facility of 0.9181 yields an adjusted labor-related amount of \$31.59. The non-labor related portion is 40% of the APC rate or \$22.94. The sum of the labor and non-labor related amounts is \$54.53. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$54.53. This amount multiplied by 200% yields a MAR of \$109.06.
 - Procedure code 99283 has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0614, which, per OPPS Addendum A, has a payment rate of \$166.45. This amount multiplied by 60% yields an unadjusted labor-related amount of \$99.87. This amount multiplied by the annual wage index for this facility of 0.9181 yields an adjusted labor-related amount of \$91.69. The non-labor related portion is 40% of the APC rate or \$66.58. The sum of the labor and non-labor related amounts is \$158.27. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$158.27. This amount multiplied by 200% yields a MAR of \$316.54.
3. The total allowable reimbursement for the services in dispute is \$425.60. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$425.60. 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 \$425.60.

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 \$425.60 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

Date

March , 2015

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.