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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Seton Northwest Hospital

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-15-2393-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
April 3, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…As the medical report shows, the procedures were medically necessary; therefore the hospital has a right to expect reimbursement."

Amount in Dispute: $454.51

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In conclusion, reimbursement is not owed for the services rendered because the Claimant's complaints were not a true emergency, and the physician was not his treating doctor."

Response Submitted by: Downs ♦ Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 10, 2014	Outpatient Emergency Services	$454.51	$454.51

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 §133.2 defines emergency
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of healthcare.
4. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient facility services provided in an acute care hospital.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – Not approved provider
   - 2 – Treatment not authorized

Issues

1. Is the definition of emergency met?
2. What is the applicable rule pertaining to fee guidelines?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code "62 – No proof of pre – auth." 28 Texas Administrative Code 133.2 (5) states, "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;" Review of the submitted medical record finds;

    a. Emergency Physician Record Page 18, – "L leg numbness chronically."

    b. Pain Assessment Page 34 – Primary Pain Intensity; 9, Primary Pain Time Pattern; Acute, Chronic

   Therefore, the Division finds based on the submitted documentation the definition of emergency is met.

   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."

   As the definition of emergency was supported by documentation submitted with this request, the Carrier is liable for the services in dispute.

2. 28 Texas Administrative Code §134.403 (f) states, "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 will be calculated as follows;
   - Procedure code 99284 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC if OPPS criteria are met; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of $293.71. This amount multiplied by 60% yields an unadjusted labor-related amount of $176.23. This amount multiplied by the annual wage index for this facility of 0.9425 yields an adjusted labor-related amount of $166.10. The non-labor related portion is 40% of the APC rate or $117.48. The sum of the labor and non-labor related amounts is $283.58. 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 $283.58. This amount multiplied by 200% yields a MAR of $567.16.
   - Per Medicare policy, procedure code 96372 may not be reported with procedure code 99284 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
   - Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code J2550 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

3. The total allowable reimbursement for the services in dispute is $567.16. The amount previously paid by the insurance carrier is $0.00. The requestor is seeking additional reimbursement in the amount of $454.51. 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 $454.51.

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 $454.51 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		April 29, 2015
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 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 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 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.