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
Doctors Hospital at Renaissance

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-17-1005-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Doctors Hospital at Renaissance is kindly requesting that the above claim be reconsidered and processed accordingly."

Amount in Dispute: $618.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester provided outpatient emergency department services to the claimant on the date above. Texas Mutual declined to issue payment as the level of documented treatment is inconsistent with the definition of a medical emergency at Rule 133.2."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 16, 2016	72100	$169.48	$0.00
September 15, 2016	99283	353.86	$344.66
September 16, 2016	J1885	$0.00	$0.00
September 16, 2016	A9270	$0.00	$0.00
September 15, 2016	96372	$95.50	$74.40
		Total	$419.06

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 provides definitions for terms related to medical billing and review.

3. 28 Texas Administrative Code §133.10 sets out the requirements for a complete medical bill.
4. 28 Texas Administrative Code §133.20 sets out the procedures for submission of a medical bill.
5. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient hospital services.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - CAC-243 – Services not authorized by network/primary care providers.
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 727 – Provider not approved to treat Texas Star Network Claimant.
   - 899 – Documentation and file review does not support an emergency in accordance with Rule 133.2.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of services.

Issues

1. What are the services considered for this dispute?
2. Are Texas Mutual Insurance Company's reasons for denial of payment supported?
3. Is Doctors Hospital at Renaissance entitled to additional reimbursement?

Findings

1. Doctors Hospital at Renaissance is seeking reimbursement for services performed in the emergency room from September 15, 2016 through September 16, 2016. Procedure codes 72100, 99283, J1885, A9270, and 96372 were included on the Medical Fee Dispute Resolution Request (DWC060). Doctors Hospital at Renaissance is seeking $0.00 for procedure codes J1885 and A9270. Therefore, these services will not be considered. Doctors Hospital at Renaissance is seeking $618.84 for procedure codes 72100, 99283, and 96372. These are the services considered in this dispute.

2. The division will consider the denial reasons presented by Texas Mutual Insurance Company (Texas Mutual) to Doctors Hospital at Renaissance below:

   CAC-243 – SERVICES NOT AUTHORIZED BY NETWORK/PRIMARY CARE PROVIDERS.
   727 – PROVIDER NOT APPROVED TO TREAT TEXAS STAR NETWORK CLAIMANT.

   On an explanation of benefits dated October 21, 2016, Texas Mutual denied the disputed services, in part, based on the above claim adjustment reason codes. Subsequent explanation of benefits and the position statement provided by Texas Mutual did not maintain these denial reasons. Submitted documentation does not include evidence to support that the claim in question is part of a certified healthcare network. The division finds that Texas Mutual's denial of payment for the reasons noted is not supported.

   CAC-16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.

   Submission of medical bills is subject to the requirements found in 28 Texas Administrative Codes §§133.10 and 133.20. Review of the submitted documentation does not find submission or billing errors. Absent support for this claim adjustment reason code, the division concludes that Texas Mutual's denial for this reason is not supported.

   899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2.

   In its position statement, Texas Mutual stated that "the level of documented treatment is inconsistent with the definition of a medical emergency at Rule 133.2." Review of submitted documentation finds that Texas Mutual failed to demonstrate that the services in question required preauthorization.

Therefore, an argument that the services were an emergency was not necessary to overcome such a requirement. The division concludes that Texas Mutual's denial of payment for this reason is not supported.

225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.

The division will consider each of the services in question:

- The American Medical Association (AMA) CPT code description for procedure code 72100 is "Radiologic examination, spine, lumbosacral; 2 or 3 views." This service is documented on page 11 of 26 of the submitted medical records.
- The AMA CPT code description for procedure code 96372 is "Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular." This service is documented on page 15 of 26 of the submitted medical records.
- The AMA CPT code description for procedure code 99283 is "Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity." The 1995 Documentation Guidelines for Evaluation & Management Services, published by the Centers for Medicare and Medicaid Services (CMS) puts forth the requirements to meet the AMA CPT code description presented. The division finds that all of the components of procedure code 99283 were met or exceeded supporting the service requested as required by 28 Texas Administrative Code §134.403. Texas Mutual's denial reason is not supported for this service.

The division finds that documentation supports each of the services in question. Reimbursement will be reviewed in accordance with applicable fee guidelines.

3. The services in question are subject to the fee guidelines found in 28 Texas Administrative Code §134.403(d), which states, in relevant part, "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 with any additions or exceptions specified in this section…"

Further, 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…

Reimbursement is determined as follows:

- Procedure code 72100 has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for any procedures with status indicator S, T or V. These services are separately payable only if no other such procedures are billed. Because procedure code 96372 has status indicator S, this procedure is not separately payable.
- Procedure code 99283 has status indicator J2, denoting hospital, clinic or emergency room visits (including observation/critical care services) subject to composite payment if certain other services are billed in combination. This is assigned APC 5023. The OPPS Addendum A rate is $195.98. This is multiplied by 60% for an unadjusted labor-related amount of $117.59, which is multiplied by the facility wage index of 0.7989 for an adjusted labor amount of $93.94. The non-labor related portion is 40% of the APC rate, or $78.39. The sum of the labor and non-labor portions is $172.33. The cost of these services does not exceed the fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific amount of $172.33 is multiplied by 200% for a MAR of $344.66.

- Procedure code 96372 has status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This is assigned APC 5692. The OPPS Addendum A rate is $42.31. This is multiplied by 60% for an unadjusted labor-related amount of $25.39, which is multiplied by the facility wage index of 0.7989 for an adjusted labor amount of $20.28. The non-labor related portion is 40% of the APC rate, or $16.92. The sum of the labor and non-labor portions is $37.20. The cost of these services does not exceed the fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific amount of $37.20 is multiplied by 200% for a MAR of $74.40.

The maximum allowable reimbursement for the eligible services is $419.06. 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 $419.06.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $419.06, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	September 5, 2018
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, 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.