TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MHHS Greater Heights

Respondent Name
Houston ISD

MFDR Tracking Number
M4-18-4219-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
July 6, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It was denied "services not provided or authorized by designated (network/primary care) providers and the charges do not meet qualifications for emergent/urgent care."

Amount in Dispute: $10,378.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is our position the requestor has not filed an MFDR in a timely manner."

Response Submitted by: Novare LLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 4 -5, 2017	Emergency Room Services	$10,378.25	$1,919.64

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 defines emergency
3. Texas Insurance Code 1305.006 sets out requirements for workers compensation healthcare networks.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 38 – Services not provided or authorized by designated (network/primary care) providers
   - 40 – Charges do not meet qualifications for emergent/urgent care

Issues

1. Did the requestor waive their right to MFDR?
2. Is the carrier's denial supported?
3. What rule is applicable to reimbursement?

Findings

1. Review of the submitted Medical Fee Dispute Request finds the dates of service is March 4 – 5, 2017, this is outside the one year requirement. However, The Division's Commissioner issued Bulletin # B-0020-17 states in pertinent part,

   "For system participants who reside in the counties listed in the Governor's disaster proclamation, the Texas workers' compensation deadlines for the following procedures are tolled through the duration of the Governor's disaster proclamation:

   - Workers' compensation claim notification and filing deadlines.

   Review of the submitted medical bill found the zip code of 77008 in Harris County. This county is found within the "Proclamation by the Governor of the State of Texas" disaster declaration. As the time period from August 23, 2017 to January 10, 2018 is within the tolled period covered by the disaster proclamation, these days are not counted towards the filing deadline. The total days consist of the date of service to August 23, 2017 then stops until January 10, 2018. The count begins again and continues until the dispute was received by MFDR or July 6, 2018. Therefore, this request was received within requirements of 28 Texas Administrative Code 133.307 (c)(1). This dispute will be reviewed per applicable fee guidelines.

2. The requestor is seeking reimbursement for outpatient hospital services rendered on March 4-5, 2017.The insurance carrier denied disputed services with claim adjustment reason code 40 – "Charges do not meet qualifications for emergent/urgent care" and "38 – "Services not provided or authorized by designated (network/primary care) provider."

   28 Texas Administrative Code §133.2 (5) defines an emergency as

   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;

   (B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

   Review of the submitted information "Emergency Department Provider Documentation" finds the following, "weakness and unable to speak started 1 hour ago. Pt has history involuntary movement per mom" and "worsening headache," "sharp jaw pain." The Division's definition of emergency is met. The carrier's denial is not supported.

   Texas Insurance Code, Sec. 1305.006 states in pertinent part,

   An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:

   (1) emergency care;

   Based on the definition of emergency being met. The network is liable for the services in dispute. The maximum allowable reimbursement (MAR) is calculated below.

3. 28 Texas Administrative Code 134.403 (f) (1) states in pertinent part,

> 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 services in dispute are calculated as follows:

- Procedure code 86140, billed March 4, 2017 has status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services. No separate reimbursement is recommended.
- Procedure code 86850, billed March 5, 2017, has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. Review of the medical bill finds code 99285 has a status indicator of V and code 96361 has a status indicator of S. No separate reimbursement is recommended.
- Procedure code 86900, billed March 5, 2017, has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. Review of the medical bill finds code 99285 has a status indicator of V and code 96361 has a status indicator of S. No separate reimbursement is recommended.
- Procedure code 86901, billed March 5, 2017, has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. Review of the medical bill finds code 99285 has a status indicator of V and code 96361 has a status indicator of S. No separate reimbursement is recommended.
- Procedure code 85025, billed March 4, 2017, has status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 85610, billed March 4, 2017, has status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 85730, billed March 4, 2017 has status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 71010, billed March 4, 2017 has status indicator Q3, denoting packaged codes paid through a composite APC (if OPPS criteria are met). As packaging criteria are not met, this line is separately paid. This line is assigned status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This code is assigned APC 5521. The OPPS Addendum A rate is $59.86. This is multiplied by 60% for an unadjusted labor-related amount of $35.92, which is multiplied by the facility wage index of 0.9653 for an adjusted labor amount of $34.67. The non-labor related portion is 40% of the APC rate, or $23.94. The sum of the labor and non-labor portions is $58.61. The Medicare facility specific amount of $58.61 is multiplied by 200% for a MAR of $117.22.
- Procedure code 70450 has status indicator Q3, denoting conditionally packaged codes paid as a composite APC (if OPPS criteria are met). As packaging criteria are not met, this line is separately paid. This line is assigned status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This code is assigned APC 5522. The OPPS Addendum A rate is $112.73. This is multiplied by 60% for an unadjusted labor-related amount of $67.64, which is multiplied by the facility wage index of 0.9653 for an adjusted labor amount of $65.29. The non-labor related portion is 40% of the APC rate, or $45.09. The sum of the labor and non-labor portions is $110.38. The Medicare facility specific amount of $110.38 is multiplied by 200% for a MAR of $220.76.

- Procedure code 99285, billed March 4, 2017, has status indicator J2, denoting outpatient visits (subject to comprehensive packaging if 8 or more hours observation billed). Review of the medical bill found no observation hours were provided therefore comprehensive packaging is not met. This code is assigned APC 5025 with a Status Indicator of V. The OPPS Addendum A rate is $488.74. This is multiplied by 60% for an unadjusted labor-related amount of $293.24, which is multiplied by the facility wage index of 0.9653 for an adjusted labor amount of $283.06. The non-labor related portion is 40% of the APC rate, or $195.50. The sum of the labor and non-labor portions is $478.56. The Medicare facility specific amount of $478.56 is multiplied by 200% for a MAR of $957.12.
- Procedure code 96361 has status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This code is assigned APC 5691. The OPPS Addendum A rate is $34.78. This is multiplied by 60% for an unadjusted labor-related amount of $20.87, which is multiplied by the facility wage index of 0.9653 for an adjusted labor amount of $20.15. The non-labor related portion is 40% of the APC rate, or $13.91. The sum of the labor and non-labor portions is $34.06. The Medicare facility specific amount of $34.06 is multiplied by 200% for a MAR of $68.12.
- Procedure code 96374 has status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This code is assigned APC 5693. The OPPS Addendum A rate is $179.77. This is multiplied by 60% for an unadjusted labor-related amount of $107.86, which is multiplied by the facility wage index of 0.9653 for an adjusted labor amount of $104.12. The non-labor related portion is 40% of the APC rate, or $71.91. The sum of the labor and non-labor portions is $176.03. The Medicare facility specific amount of $176.03 is multiplied by 200% for a MAR of $352.06.
- Procedure code 96375 has status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This code is assigned APC 5691. The OPPS Addendum A rate is $34.78. This is multiplied by 60% for an unadjusted labor-related amount of $20.87, which is multiplied by the facility wage index of 0.9653 for an adjusted labor amount of $20.15. The non-labor related portion is 40% of the APC rate, or $13.91. The sum of the labor and non-labor portions is $34.06 multiplied by 3 units is $102.18. The Medicare facility specific amount of $102.18 is multiplied by 200% for a MAR of $204.36.
- Procedure code 93005, billed March 5, 2017, has status indicator Q1, denoting STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. Review of the medical bill finds code 99285 has a status indicator of V and code 96361 has a status indicator of S. No separate reimbursement is recommended.

The total reimbursement for the disputed services is $1,919.64. 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 $1,919.64.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $1,919.64, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		August 10, 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 Rule §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. **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.