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
Hunt Regional Medical Center

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-0032-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is (injured employee) opinion that on 4/13/2018 it was medically necessary to seek emergent care for her chronic back pain. The denial for emergent care was not pre-certified and/or the treating doctor was not approved to treat is erroneous. In addition, the claim did not lack sufficient information to substantiate that treatment is determined medically necessary..."

Amount in Dispute: $5,489.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Review of the documentation does not reflect an emergent condition as defined by Rule 133.2. No payment is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 13, 2018	Outpatient Hospital Services	$5,489.98	$1,226.02

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. 28 Texas Administrative Code 134.600 sets outs requirements for prior authorization.
4. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital.

services.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 899 – Documentation and file review does not support an emergency in accordance with Rule 133.2

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?

Findings

1. The requestor is seeking additional reimbursement in the amount of $5,489.98 for outpatient hospital services rendered on April 13, 2018. The insurance carrier denied the disputed services with claim adjustment reason code 899 – "Documentation and file review does not support an emergency in accordance with Rule 133.2."

   28 TAC §134.600 (c) (1) (A) 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);

   28 TAC §133.2 (5) (A) states in pertinent part,

   > 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 documentation found:

   - Emergency room clinical report with discharge. "…It was abrupt in onset and has been constant and waxing/waning but is not gone now. It is described as being severe and in the area of the left mid lumbar spine, left lower lumbar spine, right mid lumbar spine and right lower lumbar spine. It is described as radiating to the left groin. The quality is noted to be sharp, dull and aching."
   - Physical Exam – "Appearance: Alert. Appears to be in pain. Patient in mild distress."
   - Emergency room RN notes. "Pain level 10/10."

   Based on the above, the insurance carrier's denial is not supported. The applicable DWC fee guideline is discussed below.

2. 28 TAC §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; unless
   >
   > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

Review of the medical bill finds separate payment for implants does not apply. The maximum allowable reimbursement is calculated as follows.

Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) and Status Indicator for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates and Status Indicators in the OPPS final rules, available from www.cms.gov.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 36415 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 80053 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 81001 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 85025 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure code 74176 has status indicator Q3, for conditionally packaged codes paid as a composite if OPPS criteria are met. As packaging criteria were not met, this line is separate. This code is assigned APC 5523. The OPPS Addendum A rate is $232.31, multiplied by 60% for an unadjusted labor amount of $139.39, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $135.99. The non-labor portion is 40% of the APC rate, or $92.92. The sum of the labor and non-labor portions is $228.91. The Medicare facility specific amount of $228.91 is multiplied by 200% for a MAR of $457.82.
- Procedure code 96361 has status indicator S, for procedures not subject to reduction. This code is assigned APC 5691. The OPPS Addendum A rate is $37.03, multiplied by 60% for an unadjusted labor amount of $22.22, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $21.68. The non-labor portion is 40% of the APC rate, or $14.81. The sum of the labor and non-labor portions is $36.49. The Medicare facility specific amount of $36.49 is multiplied by 200% for a MAR of $72.98.
- Procedure code 96374 has status indicator S, for procedures not subject to reduction. This code is assigned APC 5693. The OPPS Addendum A rate is $191.09, multiplied by 60% for an unadjusted labor amount of $114.65, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $111.85. The non-labor portion is 40% of the APC rate, or $76.44. The sum of the labor and non-labor portions is $188.29. The Medicare facility specific amount of $188.29 is multiplied by 200% for a MAR of $376.58.
- Procedure code 96375 has status indicator S, for procedures not subject to reduction. This code is assigned APC 5691. The OPPS Addendum A rate is $37.03, multiplied by 60% for an unadjusted labor amount of $22.22, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $21.68. The non-labor portion is 40% of the APC rate, or $14.81. The sum of the labor and non-labor portions is $36.49. The Medicare facility specific amount of $36.49 is multiplied by 200% for a MAR of $72.98.
- Procedure code 99282 has status indicator J2, for outpatient visits (subject to comprehensive packaging if eight or more hours observation billed) however as eight hours of observation does not apply, this code is assigned APC 5022. The OPPS Addendum A rate is $124.65, multiplied by 60% for an unadjusted labor amount of $74.79, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $72.97. The non-labor portion is 40% of the APC rate, or $49.86. The sum of the labor and non-labor portions is $122.83. The Medicare facility specific amount of $122.83 is multiplied by 200% for a MAR of $245.66.
- Procedure code J1885 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code J2930 has status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.

The total recommended reimbursement for the disputed services is $1,226.02. The insurance carrier paid $0.00. The amount due is $1,226.02. 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 $1,226.02.

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 $1,226.02, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		September 27, 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.