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
The Medical Center of Southeast Texas

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-4342-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 3, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted

Amount in Dispute: $526.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual Insurance argues the severity of presenting problems was non emergent per Rule 133.2. If emergent why did the patient leave prior to being seen by the doctor and why did the patient wait 3 days to go to the emergency."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 11,2019	450- Emergency Room 450 – Emergency Room	$111.18 $414.95	$111.46

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 §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. 28 Texas Administrative Code §133.2 defines emergency
4. 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
   - 193 – Original payment decision is being maintained

Issues

1. Is the insurance carriers' denial supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $526.13 for outpatient hospital services rendered on March 11, 2019. The insurance carrier reduced disputed services stating definition of emergency not met. 28 TAC 133.2 (5) 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 records page 37 of 42 finds "Numeric Pain Score (0-10) – 10.

   Based on the above, the definition of emergency is met, the insurance carriers' denial is not supported. The disputed service will be reviewed by the applicable fee guideline.

2. The applicable fee guideline is found in 28 TAC §134.403, (f) which 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.

   The maximum allowable reimbursement per the above is calculated as follows:

   - Procedure code 96372 (Therapeutic, prophylactic, or diagnostic injection) is supported by the submitted medical records, has status indicator Q1. This code is assigned APC 5692. The OPPS Addendum A rate is $59.75, multiplied by 60% for an unadjusted labor amount of $35.85, in turn multiplied by the facility wage index of 0.8878 for an adjusted labor amount of $31.83. The non-labor portion is 40% of the APC rate, or $23.90. The sum of the labor and non-labor portions is $55.73. The Medicare facility specific amount of $55.73 is multiplied by 200% for a MAR of $111.46.
   - Procedure code 99283 is defined as "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 a moderate complexity." Review of the submitted medical records found the requirements of this code is not met. No payment can be recommended.
   - 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.

3. The total recommended reimbursement for the disputed services is $111.46. 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 $111.46.

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 $111.46, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		July 10, 2019
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.