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 NORTHEAST HOSPITAL

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-4908-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 17, 2019

Response Submitted By
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"It was denied 'documentation and file review does not support an emergency in accordance with Rule 133.2'. I submitted an appeal letter based on the denial for non urgent care siting that the patient had presented to the emergency room due to experiencing low back pain, radiating to bilateral lower legs.… I have attached all available documents for your review."

RESPONDENT'S POSITION SUMMARY

"The bill was denied as documentation does not support an emergency."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 25, 2019	Outpatient Hospital Services	$6,775.00	$661.10

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 hospital facility fee guideline for outpatient services.
3. 28 Texas Administrative Code §133.2 defines words and terms related to medical bill processing.
4. Texas Labor Code §408.021 establishes an injured employee's entitlement to medical benefits.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2
   - B7 – THE PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

- DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (800) 859-5995 X3994.
- 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- 242 – NOT TREATING DOCTOR APPROVED TREATMENT.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2
   - B7 – THE PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
   - 242 – NOT TREATING DOCTOR APPROVED TREATMENT.

   The carrier's response states they "found no evidence that the treating or referring Doctor referred the patient to the Emergency Department.… The bill was denied as documentation does not support an emergency."

   Labor Code §408.021(c) requires that, "Except in an emergency, all health care must be approved or recommended by the employee's treating doctor."

   No information was found to support the injured employee was referred by the employee's treating doctor.

   28 Texas Administrative Code §133.2(5)(A), defines a medical emergency as: "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."

   The division notes the rule does not require the patient to actually *be* in jeopardy or *suffer* serious dysfunction. It is only required that the patient manifest acute *symptoms* of sufficient severity (including severe pain) that turning the patient away, without evaluation or treatment, could *be expected* (prior to rendering care and *without benefit of hindsight*) to result in serious jeopardy or dysfunction if treatment were not provided.

   Review of the Emergency Department Triage note finds the injured employee presented to the emergency room manifesting acute symptoms including lower back pain rated on a pain intensity scale from 0 to 10 as level 10.

   The medical records support that at the time employee was first assessed during triage, the employee manifested acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy or dysfunction to the patient's health, bodily functions, body parts or organs. Because this meets the definition of a medical emergency, the hospital could not in good conscience turn the patient away without further evaluation or treatment. As an emergency was supported, the disputed health care was not required to be approved or recommended by the employee's treating doctor.

   Furthermore, the division finds the medical records support the services as billed, and the provider was eligible to be paid for the procedures rendered on the service date.

   The division concludes the insurance carrier's denial reasons are not supported. The disputed services will therefore be reviewed for payment in accordance with division rules and fee guidelines.

2. This dispute regards emergency room services subject to DWC's *Hospital Facility Fee Guideline*, Rule §134.403, which requires the maximum allowable reimbursement (MAR) be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors modified by DWC rules.

   Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for the disputed hospital facility services.

Medicare assigns an Ambulatory Payment Classification (APC) to OPPS services based on billed procedure codes and supporting documentation. The APC determines the payment rate. Reimbursement for ancillary items and services is packaged with the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

Reimbursement for the disputed services is calculated as follows:

- Procedure codes 80053, 83690, 80307, 85025, and 81001 have status indicator Q4, for packaged labs; reimbursement is included in the APC payment for the primary services. Separate payment is not recommended.
- Procedure code 72131 represents a CT scan assigned APC 5522 with status indicator S. The OPPS Addendum A rate is $112.51. This is multiplied by 60% for an unadjusted labor amount of $67.51, and in turn multiplied by the facility wage index of 0.9754 for an adjusted labor amount of $65.85. The non-labor portion is 40% of the APC rate, or $45.00. The sum of the labor and non-labor portions is the Medicare facility specific amount of $110.85. This is multiplied by 200% for a MAR of $221.70.
- Procedure codes 36000 and J1885 have 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 96372 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for other services performed with status indicators S, T or V. Separate payment is not recommended.
- Procedure code 99283 represents an Emergency Department evaluation assigned APC 5023 with status indicator V. The OPPS Addendum A rate is $222.99. This is multiplied by 60% for an unadjusted labor amount of $133.79, and in turn multiplied by the facility wage index of 0.9754 for an adjusted labor amount of $130.50. The non-labor portion is 40% of the APC rate, or $89.20. The sum of the labor and non-labor portions is the Medicare facility specific amount of $219.70. This is multiplied by 200% for a MAR of $439.40.

The total recommended reimbursement for the disputed services is $661.10. The insurance carrier paid $0.00. The amount due is $661.10. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the division finds that additional payment is due. As a result, the amount ordered is $661.10.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, the division finds the requestor is entitled to additional reimbursement. The division hereby ORDERS the respondent to remit to the requestor $661.10, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	August 16, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). The division must receive the request within twenty days of your receipt of this decision.

The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 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.