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
MED CITY FORT WORTH

Respondent Name
TEXAS DEPARTMENT OF TRANSPORTATION

MFDR Tracking Number
M4-20-0084-01

Carrier's Austin Representative
Box Number 32

MFDR Date Received
September 12, 2019

Response Submitted By
IMO, Injury Management Organization, Inc.

REQUESTOR'S POSITION SUMMARY

"The patient was noted to have post-operative complications of altered mental status… was noted as tachycardic with low grade fever… Due to continued confusion the decision was made to transfer the patient to Plaza Medical Center of Fort Worth for a higher level of care."

RESPONDENT'S POSITION SUMMARY

"The provider did not submit a Pre-Authorization request prior to performing the services therefore, services performed on 1/19/18-1/23/18 [*sic*] requiring Pre-Authorization are denied."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 19, 2019 to January 23, 2019	Inpatient Hospital Services	$35,071.84	$20,461.98

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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the hospital facility fee guideline for inpatient services.
3. 28 Texas Administrative Code §134.600 sets out requirements regarding authorization of health care.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
   - 18 – EXACT DUPLICATE CLAIM/SERVICE
   - 247 – A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE

Issues

1. Was preauthorization required?
2. Is the requestor entitled to payment?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code:
   - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.

   28 Texas Administrative Code §134.600 §134.600(c)(1)(A), requires the insurance carrier to be liable for all reasonable and necessary medical costs relating to the health care in "an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions)." Preauthorization is *not required* in an emergency.

   The documentation supports that the self-insured employer was notified of the transfer and informed the provider that "no precertification was needed for inpatient emergency admission."

   28 TAC §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."

   Following surgery at another hospital, the injured employee was transferred to the facility for the purpose of "a higher level of care," due to experiencing post-operative complications including symptoms of altered mental status, tachycardia, fever, embolism of the lung, and continued confusion.

   The submitted documentation supports the reasonable expectation at the time of admission that the absence of immediate medical attention could result in serious jeopardy or dysfunction to the patient's health, bodily functions, body parts or organs. A medical emergency is therefore supported.

   Because a medical emergency is supported, preauthorization was not required. The carrier's denial reasons are not supported. The disputed services will therefore be reviewed for payment in accordance with DWC fee guidelines.

2. This dispute regards inpatient services with payment subject to the *Hospital Facility Fee Guideline—Inpatient*, 28 TAC §134.404, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Inpatient Prospective Payment System (IPPS) formulas and factors with modifications set out in the rule. Medicare IPPS formulas and factors are available from www.cms.gov.

   Separate reimbursement for implantables was not requested; accordingly, Rule §134.404(f)(1)(A) requires that for these services the Medicare facility specific amount, including any outlier payment, be multiplied by 143%.

   DWC calculates the Medicare facility specific amount using Medicare's *Inpatient PPS PC Pricer* as a tool to efficiently identify and apply IPPS formulas and factors. This software is also freely available from www.cms.gov.

   Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 871. The service location is Fort Worth, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $14,309.08. This amount multiplied by 143% results in a MAR of $20,461.98.

   The total recommended payment for the disputed services is $20,461.98. The insurance carrier paid $0.00. The amount due is $20,461.98. 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 requestor has not established that additional payment is due. As a result, the amount ordered is $20,461.98.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $20,461.98, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	September 25, 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 28 TAC §133.307.

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

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.