Texas Department of Insurance
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SOUTH TEXAS HEALTH SYSTEM

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-20-0372-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 10, 2019

Response Submitted By
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"the Claimant was suffering from a recent onset of back pain. It is reasonable to assume that this led the Claimant to believe that a delay in treatment would put him at risk of 'serious dysfunction of any body organ or part.'"

RESPONDENT'S POSITION SUMMARY

"Staff reviewed the documentation and found no evidence that the treating or referring Doctor referred the patient to the Emergency Department."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 11, 2019	Outpatient Hospital Services	$31,810.00	$1,994.86

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) in Title 28, Part 2 of the Texas Administrative Code.

Background

1. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
4. 28 Texas Administrative Code §134.600 sets out requirements regarding authorization of health care.
5. Texas Labor Code §408.021 establishes an injured employee's entitlement to medical benefits.
6. The insurance carrier denied 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.
   - 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.
   - 242 – NOT TREATING DOCTOR APPROVED TREATMENT.

   DWC notes that Rule 28 TAC §134.600 does not require preauthorization for evaluations or outpatient hospital services that do not involve *surgery*. Therefore, preauthorization or precertification was not required for any services performed following division treatment guidelines — which these services meet.

   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."

   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."

   DWC 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 Physician Record finds the injured employee presented to the emergency room with symptoms of back pain. While the employee's struggle with back pain is documented as "chronic," the symptoms worsened in a sudden onset the day of treatment: "just prior to arrival after … getting out of his truck and stepped wrong causing him to twist his back." Those symptoms are described as "constant and worsening" with no relieving factors. DWC thus finds the medical record documents the patient presented with sufficient symptoms to support an emergency. It was reasonable for hospital staff to expect that, without evaluation, the patient could suffer serious jeopardy to health or bodily functions. As such, the hospital could not in good conscience have turned the patient away without further evaluation or treatment. This meets the definition of a medical emergency.

   Because a medical emergency was supported, approval or recommendation from the employee's treating doctor was not required for the disputed health care. The insurance carrier's denial reasons are not supported. The disputed services will therefore be reviewed for payment consistent with DWC rules and fee guidelines.

2. This dispute regards Emergency Room services subject to DWC's *Hospital Facility Fee Guideline*, 28 TAC §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 28 TAC §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 is calculated as follows:

   - Procedure codes 36415, 80053, 80307, 82550, 85025, and 81003 have status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
   - Procedure codes 72100, 96372, and 93005 have status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for other services with status indicator S, T or V performed on the same bill.
   - Procedure codes C9113, J1885, and J2405 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 71045 is an X-ray service assigned APC 5521. The OPPS Addendum A rate is $62.30, multiplied by 60% for an unadjusted labor amount of $37.38, in turn multiplied by facility wage index 0.876 for an adjusted labor amount of $32.74. The non-labor portion is 40% of the APC rate, or $24.92. The sum of the labor and non-labor portions is the Medicare facility specific amount of $57.66. This is multiplied by 200% for a MAR of $115.32.
- Procedure codes 72128, and 72131 have status indicator Q3, for packaged codes paid through a composite APC. Composites represent major components of a single episode of care; the hospital receives one payment for any combination of designated procedures. These services are assigned composite APC 8005 for CT services (computed tomography) without contrast. The OPPS Addendum A rate is $264.95, multiplied by 60% for an unadjusted labor amount of $158.97, in turn multiplied by facility wage index 0.876 for an adjusted labor amount of $139.26. The non-labor portion is 40% of the APC rate, or $105.98. The sum of the labor and non-labor portions is the Medicare facility specific amount of $245.24. This is multiplied by 200% for a MAR of $490.48.
- Procedure code 96374 is assigned APC 5693. The OPPS Addendum A rate is $187.18, multiplied by 60% for an unadjusted labor amount of $112.31, in turn multiplied by facility wage index 0.876 for an adjusted labor amount of $98.38. The non-labor portion is 40% of the APC rate, or $74.87. The sum of the labor and non-labor portions is the Medicare facility specific amount of $173.25. This is multiplied by 200% for a MAR of $346.50.
- Procedure code 96375 is assigned APC 5691. The OPPS Addendum A rate is $37.88, multiplied by 60% for an unadjusted labor amount of $22.73, in turn multiplied by facility wage index 0.876 for an adjusted labor amount of $19.91. The non-labor portion is 40% of the APC rate, or $15.15. The sum of the labor and non-labor portions is the Medicare facility specific amount of $35.06. This is multiplied by 200% for a MAR of $70.12.
- Procedure code 99285 is assigned APC 5025. The OPPS Addendum A rate is $525.30, multiplied by 60% for an unadjusted labor amount of $315.18, in turn multiplied by facility wage index 0.876 for an adjusted labor amount of $276.10. The non-labor portion is 40% of the APC rate, or $210.12. The sum of the labor and non-labor portions is the Medicare facility specific amount of $486.22. This is multiplied by 200% for a MAR of $972.44.

The total recommended reimbursement for the disputed services is $1,994.86. The insurance carrier paid $0.00. The amount due is $1,994.86. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of the division is to adjudicate payment following Texas laws and DWC 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, additional payment is due. As a result, the amount ordered is $1,994.86.

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 $1,994.86, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

______________________	Grayson Richardson	November 8, 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.