MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baptist St Anthonys Hospital

Respondent Name
Kiewit Corp

MFDR Tracking Number
M4-20-0576-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 29, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "None submitted"

Amount in Dispute: $1,236.09

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider did not pursue a request for preauthorization prior to treating the claimant. Preauthorization was required."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 22, 2019	Outpatient Hospital Services	$1,236.09	$1,236.09

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 out 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 or denied the payment for the disputed services with the following claim adjustment codes:
   - 197- Payment denied/reduced for absence of precertification/authorization
   - 5264 – Payment is denied-service not authorized

Issues

1. Was prior authorization required?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

The respondent states in their position, "The services in questions are not related to the [redacted] date of injury" and a PLN11 was included with their response. 28 TAC §133.307 (F) allows MFDR to consider and address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division. A denial for relatedness was not presented on the submitted explanation of benefits. The review will be only on the denial reason "prior authorization."

1. The requestor is seeking additional reimbursement in the amount of $1,236.09 for outpatient hospital services rendered on February 22, 2019. The insurance carrier denied the disputed services based on lack of preauthorization.

   28 TAC §134.600 (p) (2) requires non-emergency health care including outpatient surgical or ambulatory surgical service require preauthorization

   28 TAC §133.2 (5) defines an 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 placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction of any body organ or part.

   Review of the submitted documentation found the claimant reported sudden and constant pain worsened by turning on the back stimulator.

   Based on the above the insurance carrier's denial for lack of prior authorization is not supported.

2. 28 TAC §134.403 (d) requires Texas workers' compensation system participants to apply Medicare payment polices in effect on the date of service when coding, billing, reporting and reimbursement.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators.

   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.

   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 (if applicable) 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.

   When implants are not requested, the sum of the Medicare facility specific reimbursement amount shall be multiplied by 200 percent.

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

   - Procedure code 72131 has status indicator Q3, for conditionally packaged codes. Packaging criteria was not met so this code is assigned APC 5522.

     The OPPS Addendum A rate is $112.51, multiplied by 60% for an unadjusted labor amount of $67.51, in turn multiplied by the facility wage index of 0.8154 for an adjusted labor amount of $55.05.

     The non-labor portion is 40% of the APC rate, or $45.00. The sum of the labor and non-labor portions is $100.05. The cost of services does not exceed the threshold for outlier payment.

     The Medicare facility specific amount of $100.05 is multiplied by 200% for a MAR of $200.10.

   - Procedure code 96374 has status indicator S and 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 the facility wage index of 0.8154 for an adjusted labor amount of $91.58.

The non-labor portion is 40% of the APC rate, or $74.87. The sum of the labor and non-labor portions is $166.45. The cost of services does not exceed the threshold for outlier payment.

The Medicare facility specific amount of $166.45 is multiplied by 200% for a MAR of $332.90.

- Procedure code 96375 has status indicator S and 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 the facility wage index of 0.8154 for an adjusted labor amount of $18.53.

  The non-labor portion is 40% of the APC rate, or $15.15. The sum of the labor and non-labor portions is $33.68. The cost of services does not exceed the threshold for outlier payment.

  The Medicare facility specific amount of $33.68 is multiplied by 200% for a MAR of $67.36.

- Procedure code 99284 has status indicator V as the criteria for comprehensive observation (J2) is not met. The assigned APC is 5024. The OPPS Addendum A rate is $360.37, multiplied by 60% for an unadjusted labor amount of $216.22, in turn multiplied by the facility wage index of 0.8154 for an adjusted labor amount of $176.31.

  The non-labor portion is 40% of the APC rate, or $144.15. The sum of the labor and non-labor portions is $320.46. The cost of services does not exceed the threshold for outlier payment.

  The Medicare facility specific amount of $320.46 is multiplied by 200% for a MAR of $640.92.

- Procedure code J2270 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 J2405 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 $1,241.28. The insurance carrier paid $0.00. The requestor is seeking additional reimbursement of $1,236.09. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC 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 the requestor has established payment is due. As a result, the amount ordered is $1,236.09.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is/is not entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $1,236.09, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Peggy Miller	December 6, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

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