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
Texas Health Fort Worth

Respondent Name
Tx Public School WC Project

MFDR Tracking Number
M4-20-1283-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
January 22, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This bill was denied for multiple reasons, one being extent of injury. A BRC was held 12/19/19 at that time a DD report was presented showing the illness was not the result of the injury, however the medication required for the injury resulted in the conditions the patient was treated for. The carrier updated the PLN on 12/20/20, which I have attached."

Amount in Dispute: $17,502.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The disputed services involve an inpatient stay with surgery. Texas Health was aware that this was a workers' compensation claim from the outset of its treatment of claimant. Therefore, upon receipt of Texas Health's hospital bill, CRF denied payment for the services in question based on an absence of preauthorization. (As a side note, CRF would acknowledge that the issue of extent of injury was resolved by a Division-appointed designated doctor)."

Response Submitted by: Creative Risk Funding

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 4 – 10, 2019	Inpatient hospital services	$17,502.25	$17,420.30

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 §133.20 defines emergency.
3. 28 Texas Administrative Code §134.600 sets out the requirements for prior authorization.
4. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization
   - 216 – Based on the findings of a review organization

- 219 – Based on extent of injury

Issues

1. Was the denial for extent of injury maintained?
2. Is the insurance carrier's position supported?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. Is the requestor entitled to additional payment?

Findings

1. The respondent states in their position, "…CRF would acknowledge that the issue of extent of injury was resolved by a Division-appointed designated doctor)." Based on this response, DWC find the denial for extent of injury was not maintained.
2. The insurance carrier denied disputed services with claim adjustment reason based on lack of preauthorization. 28 TAC §133.2 (5)(A) defines an emergency as either a medical or mental health 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 placing the patient's health or bodily functions in serious jeopardy.

   Review of the submitted H&P for the treating facility assessment, "Acute blood loss anemia, Left leg DVT (HCC)."

   28 TAC §134.600 (c) (1) (A) states in pertinent part the insurance carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) or (q) of this section in the emergency.

   DWC finds the documentation supports an emergency. 28 TAC §134.600 (9) (1) states **non-emergency** inpatient hospital admissions require preauthorization. The insurance carrier's denial is not supported. The services in dispute will be reviewed per applicable fee guidelines.
3. 28 Texas Administrative Code §134.404(f), requires 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, as published annually in the Federal Register, with modifications set forth in the rules. Medicare IPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

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

   Note: the "VBP adjustment" listed in the *PC Pricer* was removed in calculating the facility amount for this admission. Medicare's Value-Based Purchasing (VBP) program is an initiative to improve quality of care in the Medicare system.

   However, such programs conflict with Texas Labor Code sections 413.0511 and 413.0512 regarding review and monitoring of health care quality in the Texas workers' compensation system. Rule §134.404(d)(1) requires that specific Labor Code provisions and division rules take precedence over conflicting CMS provisions for administering Medicare. Consequently, VBP adjustments are not considered in determining the facility reimbursement.
4. Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 803. The service location is Fort Worth, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is $12,182.03. This amount multiplied by 143% results in a MAR of $17,420.30. 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 $17,420.30.

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 $17,420.30, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		February 19 , 2020
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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.