TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Christus Santa Rosa Healthcare

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-21-2362-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
August 18, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 17, 2021	96372	1176.76	$0.00
January 17, 2021	99283	2154.56	$443.56
January 17, 2021	J2270	88.05	$0.00
January 17, 2021	J1885	80.72	$0.00
	Total	$3500.09	$443.56

Requestor's Position

The requestor did not submit a position summary but rather a copy of their reconsideration request that states, "Please note that medical notes stated that patient was experiencing (redacted) and sought medical attention.

Amount in Dispute: $3,500.09

Respondent's Position

...The bill was denied as documentation does not support an emergency. ...No payment is due.

Response Submitted by: Texas Mutual

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §133.2 defines an emergency.

3. 28 TAC §134.403 sets out the reimbursement guidelines for outpatient hospital services.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 225 – Documentation does not support a life threatening condition
- 899 – Documentation and file review does not support an emergency in accordance with Rule 133.2
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

Issues

1. Is the insurance carriers' denial supported?

2. What rule applies for determining reimbursement for the disputed services?

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of services rendered in an outpatient hospital setting on January 17, 2021. The insurance carrier denied the services stating the definition of an emergency not met. DWC Rule 28 TAC 133.2 (5) (A) states in pertinent part, "a medical 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 "Emergency room record" found the injured worker's reported pain began earlier in the morning, was severe, and that when prescribed pain medication was taken the pain level remained 10/10. The injured worker then came to the emergency room.

The insurance carrier's denial is not supported as the onset was the day the injured worker was seen, and the prescribed pain medication did not relieve the severity of the pain.

The services in dispute will be reviewed per applicable fee guideline.

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

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 and Ambulatory Payment Category (APC).

28 TAC 134.403 (f) states in pertinent part the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined 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*.

The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non-labor portion determines the Medicare specific amount. Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

- Procedure code 96372 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V.
- Procedure code 99283 has status indicator J2 as comprehensive APC when billed with 8 or more hours observation. The comprehensive criteria was not met on this claim. This code is assigned APC 5023 with a status indicator of V. The OPPS Addendum A rate is $231.60. This is multiplied by 60% for an unadjusted labor amount of $138.96, in turn multiplied by facility wage index 0.9293 for an adjusted labor amount of $129.14.

  The non-labor portion is 40% of the APC rate, or $92.64.

  The sum of the labor and non-labor portions is $221.78.

  The Medicare facility specific amount is $221.78 multiplied by 200% for a MAR of $443.56.
- Procedure code J2270 has status indicator N reimbursement is included with payment for the primary services.

- Procedure code J1885 has status indicator N reimbursement is included with payment for the primary services.

3. The total recommended reimbursement for the disputed services is $443.56. The insurance carrier paid $0.00. The amount due is $443.56. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement of $443.56 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Texas Mutual must remit to Christus Santa Rosa Healthcare $443.56 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September 16,, 2021
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.