



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

TOMBALL REGIONAL MEDICAL CENTER

Respondent Name

TEXAS PUBLIC SCHOOL WC PROJECT

MFDR Tracking Number

M4-16-1176-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

January 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Tomball Regional Medical Center has received a denial of inpatient coverage for the above-mentioned dates of service because of the absence of precertification/authorization. . . . We disagree with this decision and request approval based on medical necessity as the following supporting evidence will show."

Amount in Dispute: \$155,228.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor was aware that this was a workers' compensation claim from the outset of its treatment of the injured employee. As such, Requestor was required to request preauthorization for the services in dispute in accordance with Division Rule 134.600(p). . . . the medical evidence provided by Requestor does not support that Requestor's failure to request preauthorization for four days of inpatient hospital care and a surgery was justified or otherwise excused under the limited 'emergency' exception."

Response Submitted by: Creative Risk Funding

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 4, 2015 to May 8, 2015	Outpatient Hospital Services	\$155,228.50	\$22,822.46

Background

- 28 Texas Administrative Code §133.2 sets out definitions of terms related to medical bill processing.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.404 sets out the hospital facility fee guideline for inpatient services.
- 28 Texas Administrative Code §134.600 sets out requirements regarding authorization of health care.
- Texas Labor Code §408.021 establishes an injured employee's entitlement to health care.
- The insurance carrier denied payment for the disputed services with the following claim adjustment codes:
 - 15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.
 - 197 – Payment denied/reduced for absence of precertification/authorization

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional payment?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
 - 15 – The authorization number is missing, invalid, or does not apply to the billed services or provider.
 - 197 – Payment denied/reduced for absence of precertification/authorization

Texas Labor Code §408.021(a) states that an employee who sustains a compensable injury is entitled to:

all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.

28 Texas Administrative Code §134.600(c)(1) requires that an insurance carrier is liable for all reasonable and necessary health care listed in §134.600(p) or (q) only when the following situations occur:

- (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
- (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

Rule §134.600(p)(1) states that non-emergency health care requiring preauthorization includes "inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay."

The disputed services involve an inpatient hospital admission.

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.

The division notes the definition does not require the patient to actually *be* in jeopardy or *suffer* serious dysfunction. Rather, the patient must manifest acute *symptoms* of such severity (including severe pain) that the absence of immediate medical attention could *reasonably be expected* (prior to rendering services and without the benefit of hindsight) to result in serious jeopardy or dysfunction if treatment is not provided.

Review of the submitted documentation finds that the injured employee was treated (among other things) for a hip fracture (displaced fracture of the femoral neck) as well as a wrist fracture. Based on the medical records, the division concludes that a medical emergency is supported. The division further finds that this medical emergency existed at the time of admission and persisted through the time of the principal procedure. As such, the hospital could not have in good conscience turned the patient away without treatment.

That the hospital attempted and failed to obtain preauthorization is irrelevant in the case of a medical emergency. Emergency health care does not require preauthorization according to Rule sections 134.600 (c) and (p).

The insurance carrier has failed to support its reasons for denial of payment. The disputed services will therefore be reviewed for reimbursement in accordance with applicable division rules and fee guidelines.

2. This dispute regards inpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.404(f), 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, 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 implants was not requested. Rule §134.404(f)(1)(A) requires that, for these services, the Medicare facility specific amount, including any outlier payment, be multiplied by 143%.

Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 469. The service location is Tomball, Texas. Discharge status 62 indicates post-acute transfer to an inpatient rehabilitation facility. Based on DRG code, service location and bill-specific information, the Medicare facility specific amount is \$15,959.76. This amount multiplied by 143% results in a MAR of \$22,822.46.

3. The total recommended payment for the services in dispute is \$22,822.46. The insurance carrier has paid \$0.00. The amount due to the requestor is \$22,822.46.

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 division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

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 \$22,822.46.

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 \$22,822.46, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	<u>Grayson Richardson</u>	<u>May 4, 2018</u>
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.