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
MEDSPRING URGENT CARE

Respondent Name
SERVICE LLOYDS INSURANCE COMPANY

MFDR Tracking Number
M4-16-2620-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
April 29, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our commitment to the well-being of our patient makes it difficult for us to deny treatment simply because we are not in –network with a patient's worker's compensation insurance. . . . an injured employee can obtain treatment from an out of network treating doctor if that doctor provides emergency care services. As an urgent care provider, we do exactly that."

Amount in Dispute: $470.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As the treatment provide to the IW . . . was not emergent care as defined . . . the employee was required to seek treatment from the list of network providers."

Response Submitted by: CorVel Healthcare Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 25, 2015	Professional Medical Services	$470.00	$266.17

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 §133.2 sets out definitions of terms related to medical bill processing.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
4. 28 Texas Administrative Code §134.600 sets out requirements regarding authorization of health care.
5. Insurance Code §1305.004 defines terms related to workers' compensation health care networks.
6. Insurance Code §1305.006(1) establishes insurance carrier liability for out-of-network emergency care.
7. Insurance Code §1305.104 sets out requirements regarding initial choice of treating doctor.
8. Insurance Code §1305.153 sets out requirements regarding payment of network and non-network providers.
9. Insurance Code §1305.302 sets out requirements regarding accessibility of health care.
10. Insurance Code §1305.351 sets out requirements regarding utilization review of health care.

11. Insurance Code §1305.353 sets out requirements regarding preauthorization of health care.
12. The requestor is a non-network provider that rendered out-of-network treatment to a network claimant. Texas Insurance Code §1305.153(c) requires that out-of-network providers shall be reimbursed as provided by the Texas Workers' Compensation Act and division rules.
13. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 196 – Non Network Provider
    - B5 – Pymnt Adj/Program guidelines not met or exceeded.
    - W3 – Appeal/Reconsideration
    - 73 – Work Status Report
    - RT – Right Side

Issues

1. Is the claim subject to a workers' compensation health care network established in accordance with Insurance Code Chapter 1305?
2. Does the documentation support a medical emergency?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. Based on information maintained by the division, the division finds the insurance carrier has not reported to the division that this injured worker's claim is subject to a workers' compensation health care network (HCN) established in accordance with Insurance Code Chapter 1305.

   Rule §133.240(f)(15) requires that the paper form of an explanation of benefits (EOB) shall include the workers' compensation health care network name (if applicable). Review of the submitted explanation of benefits denying payment for the disputed bill finds the fields indicating the network name to be blank. No notice of any name of a workers' compensation HCN established in accordance with Insurance Code Chapter 1305 was found elsewhere on the EOB. The division therefore finds the insurance carrier has failed to meet the requirements of Rule §133.240(f)(15).

   Moreover, the EOB does not reference any network policies, rules or contract provisions but rather advises that "payment by the carrier will be reviewed according to the medical policies and fee guidelines established by the Division."

   The EOB further advises that "pursuant to 133.250 of this title, the health care provider may file an appeal with the insurance carrier if the health care provider disagrees with the insurance carrier's determination"

   28 Texas Administrative Code §133.307(d)(2)(F) states that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." To the extent that the respondent has raised new defenses in their position statement, the division concludes the carrier has waived the right to raise any such defenses at MFDR. Any newly raised denial reasons or defenses shall not be considered in this review.

   Accordingly, the division concludes the respondent has waived the right to assert the claim is subject to a workers' compensation HCN established under Insurance Code Chapter 1305.

   Regardless, Insurance Code §1305.153(c) requires that out-of-network providers who render treatment to a network claimant shall be reimbursed as provided by the Texas Workers' Compensation Act and division rules. Accordingly, the disputed services will be reviewed for reimbursement according to applicable division rules and fee guidelines.

2. The health care provider is an urgent care clinic that rendered services to an injured employee.

   The respondent asserts, "the employee was notified by the employer that "in the event of an injury, the employee must select a treating doctor: (a) from a list of all the network's treating doctors who have contracts with the network in that service area . . . "

   Firstly, the division has found above that the insurance carrier has waived the right to assert the claim is subject to a workers' compensation HCN established under Insurance Code Chapter 1305.

   Secondly, Insurance Code §1305.104(a)(2) establishes that a doctor providing emergency care does not constitute an initial choice of treating doctor.

   Thirdly, Insurance Code §1305.302(e) requires that "emergency care must be available and accessible 24 hours a day, seven days a week, without restrictions as to where the services are rendered."

   The health care provider asserts, "an injured employee can obtain treatment from an out of network treating doctor if that doctor provides emergency care services."

   Insurance Code §1305.006(1) states an insurance carrier is liable for emergency out-of-network health care.

   Insurance Code §1305.353(h) states, "Treatments and services for an emergency do not require preauthorization." Additionally, Insurance Code §1305.351(c) states, "an insurance carrier may not require preauthorization of treatments and services for a medical emergency."

   Likewise, corresponding division Rule §134.600(c)(1)(A) requires that an insurance carrier is liable for all reasonable and necessary health care in an emergency, as defined in 28 Texas Administrative Code Chapter 133.

   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."

   Insurance Code §1305.004(a)(13) uses language identical to Rule §133.2(5)(A) to define "Medical emergency."

   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 medical records finds that the health care provider has documented sudden onset of the medical condition, and acute symptoms of sufficient severity including pain as well as dysfunction in the knees, leg, and wrist, with further pain in the thumb described as sharp and shooting. The division finds the record sufficient to support that, based on the symptoms as presented, the absence of immediate medical attention could *reasonably be expected* to result in serious jeopardy to the health, bodily function, or serious dysfunction of various body parts. As such, the health care provider could not have in good conscience turned the patient away without treatment. The division thus concludes that the requirements for a medical emergency are supported.

   Consequently, preauthorization was not required and the insurance carrier is liable for the disputed emergency health care per Rule §134.600(c)(1)(A) and/or Insurance Code §1305.006(1).

3. This dispute regards payment of medical services with reimbursement subject to the division's *Medical Fee Guideline for Professional Services*, at 28 Texas Administrative Code §134.203, which requires that to determine the maximum allowable reimbursement (MAR), system participants shall apply Medicare payment policies with minimal modifications as set forth in the rule. Rule §134.203(c) specifies that:

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. . .
   (2) The conversion factors listed in paragraph (1) . . . shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors. . . .

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the applicable division conversion factor for calendar year 2015 of $56.20.

Reimbursement is calculated as follows:

- Procedure code 99203 has a relative value (RVU) for work of 1.42 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 1.44698. The practice expense (PE) RVU of 1.48 multiplied by the PE GPCI of 1.006 is 1.48888. The malpractice RVU of 0.15 multiplied by the malpractice GPCI of 0.955 is 0.14325. The sum of 3.07911 is multiplied by the Division conversion factor of $56.20 for a MAR of $173.05.
- Procedure code 73130 has a relative value (RVU) for work of 0.17 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.17323. The practice expense (PE) RVU of 0.66 multiplied by the PE GPCI of 1.006 is 0.66396. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.85629 is multiplied by the Division conversion factor of $56.20 for a MAR of $48.12.
- Procedure code L3807 represents a wrist orthotic/splint with reimbursement determined per §134.203(d). The fee listed for this code in the Medicare DMEPOS fee schedule is $218.99. 125% of this amount is $273.74. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is the provider's billed charge of $30.00.
- Procedure code 99080 is a division specific code for a work status report with reimbursement subject to 28 Texas Administrative Code §129.5(i), which requires that "reimbursement shall be $15."

4. The total allowable reimbursement for the services in dispute is $266.17. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $266.17. This amount is recommended.

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 $266.17.

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 $266.17, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	March 29, 2018
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.