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
HOUSTON HOSPITAL FOR SPECIALIZED SURGERY

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-17-0445-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient … had recently applied substantial force to the repaired digit, heard a resounding pop, give way at the application of force, and felt a small explosion occurring in the repaired digit. An MRI … confirmed the rupture of a previous.ly successful repair. … prior-authorization was not obtained due to emergency case status."

Amount in Dispute: $16,840.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Because this fee reimbursement dispute involves a Network requirement under the Insurance Code and not the Labor Code, Texas Mutual argues DWC MDR has no jurisdiction in this matter."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 26, 2016	Outpatient Hospital Services	$16,840.00	$4,680.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Insurance Code Chapter 1305, 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 §134.403 sets out the acute care hospital fee guideline for outpatient services.
4. Insurance Code §1305.004 defines terms related to workers' compensation health care networks.
5. Insurance Code §1305.006 establishes insurance carrier liability for out-of-network health care.
6. Insurance Code §1305.153 sets out requirements regarding payment of network and non-network providers.
7. Insurance Code §1305.302 sets out requirements regarding accessibility of health care.
8. Insurance Code §1305.351 sets out requirements regarding utilization review of health care.
9. Insurance Code §1305.353 sets out requirements regarding preauthorization of health care.

10. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 197 – PRECERTIFICATION/AUTHORIZATION ABSENT
    - 243 – SERVICES NOT AUTHORIZED BY NETWORK/PRIMARY CARE PROVIDERS.
    - 727 – PROVIDER NOT APPROVED TO TREAT TEXAS STAR NETWORK CLAIMANT. FOR NETWORK INFORMATION CALL 800-381-8067.
    - 786 – DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.
    - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
    - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
    - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
    - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824

Issues

1. Under what authority is this dispute decided?
2. Are the insurance carrier's reasons for denial of payment supported?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor provided services to an injured employee enrolled in the Texas Star Network, a certified workers' compensation health care network (HCN) established in accordance with Insurance Code Chapter 1305. The health care provider requests medical fee dispute resolution (MFDR) through the division's MFDR section as an out-of-network healthcare provider.

   Insurance Code §1305.006 sets out the circumstances under which an insurance carrier that establishes or contracts with a network is liable for out-of-network health care provided to an injured employee.

   Insurance Code §1305.153 (c) further requires that out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation.

   The authority of the Division of Workers' Compensation to review disputes involving out-of-network health care provided to employees enrolled in a certified workers' compensation HCN is established in applicable provisions of the Texas Insurance Code, pursuant to the Texas Labor Code and division rules, including Rule §133.307.

2. The insurance carrier denied disputed services with claim adjustment reason codes:
    - 197 – PRECERTIFICATION/AUTHORIZATION ABSENT
    - 243 – SERVICES NOT AUTHORIZED BY NETWORK/PRIMARY CARE PROVIDERS.
    - 727 – PROVIDER NOT APPROVED TO TREAT TEXAS STAR NETWORK CLAIMANT. FOR NETWORK INFORMATION CALL 800-381-8067.
    - 786 – DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.

   Insurance Code §1305.006 outlines the insurance carrier's liability for out-of-network healthcare. Subsection 1305.006 (1) requires that an insurance carrier that establishes or contracts with a network is liable for emergency care provided to an injured employee.

   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."

   Insurance Code §1305.353 (h) states, "Treatments and services for an emergency do not require preauthorization."

   Insurance Code §1305.351 (c) further states that "an insurance carrier may not require preauthorization of treatments and services for a medical emergency."

   Insurance Code §1305.004(a)(13) and corresponding division Rule §133.2(5)(A) both define 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 placing the patient's health or bodily functions in serious jeopardy; or serious dysfunction of any body part or organ.

The division notes the definition does not require the patient to actually *be* in jeopardy or *suffer* serious dysfunction. Rather, the patient must manifest severe enough *symptoms* (such as 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.

Upon review of the submitted medical records, the division finds a medical emergency to be documented and supported. The division concludes that prior to rendering the services, the presented symptoms were of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy or dysfunction and therefore the provider could not have in good conscience turned the patient away without treatment. As a medical emergency is supported, preauthorization was not required for the disputed services and network pre-approval was not required for the provider to treat the injured employee.

The insurance carrier's denial reasons are not supported. The disputed services will therefore be reviewed for payment in accordance with applicable division rules and fee guidelines.

3. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors, as published annually in the Federal Register, with modifications set forth in the rules. Medicare OPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at http://www.cms.gov.

   Rule §134.403(f)(1) requires the sum of the Medicare facility specific amount and any outlier payments be multiplied by 200 percent. Separate reimbursement for implants was not requested.

   Medicare assigns an Ambulatory Payment Classification (APC) to OPPS services based on billed procedure codes and supporting documentation. The APC determines the payment rate. Reimbursement for ancillary items and services is packaged with the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure codes J1170, J2175, J2405, J3010 and C1713 have status indicators of N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
   - Procedure code 26357 has status indicator T, denoting a significant outpatient procedure. This procedure is assigned to APC 5122. The OPPS Addendum A rate is $2,395.59, which is multiplied by 60% for an unadjusted labor-related amount of $1,437.35, which is in turn multiplied by the facility wage index of 0.9615 for an adjusted labor amount of $1,382.01. The non-labor related portion is 40% of the APC rate, or $958.24. The sum of the labor and non-labor portions is $2,340.25. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $2,340.25 is multiplied by 200% for a MAR of $4,680.50.

4. The total recommended reimbursement for the disputed services is $4,680.50. The insurance carrier has paid $0.00, leaving an amount due to the requestor of $4,680.50. 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 $4,680.50.

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 $4,680.50, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	April 6, 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.