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
BAYLOR UNIVERSITY MEDICAL CENTER

Respondent Name
LM INSURANCE CORPORATION

MFDR Tracking Number
M4-18-3420-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 16, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Liberty mutual insurance had denied claim as provider is not within the liberty health care network. Authorization were requested and the adjuster . . . had stated that patient claim was open, no authorization for ER visit."

Amount in Dispute: $15,611.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Although the injured employee was admitted through the emergency room, it is our position that the patient was very much aware of Network requirements and should have chosen an in Network facility."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 10, 2017 to November 13, 2017	Outpatient Hospital Services – Emergency Room Visit	$15,611.39	$4,390.34

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031, Texas Insurance Code Chapter 1305, 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 §134.403 sets out the hospital facility fee guideline for outpatient services.
3. 28 Texas Administrative Code §133.2 sets out definitions of terms related to medical bill processing.
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 1305.005 sets out requirements regarding notice to injured employees.
7. Insurance Code 1305.006 establishes insurance carrier liability for out-of-network health care.
8. Insurance Code 1305.153 sets out requirements for 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 network utilization review.

11. Insurance Code 1305.353 sets out requirements regarding preauthorization of health care.
12. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - X397 – PROVIDER IS NOT WITHIN THE LIBERTY HEALTH CARE NETWORK (HCN) FOR THIS CUSTOMER. TX INSURANCE CODE 1305.004 (B) AND LABOR CODE 401.011.
    - 193 – PROVIDER IS NOT WITHIN THE LIBERTY HEALTH CARE NETWORK (HCN) FOR THIS CUSTOMER. TX INSURANCE CODE 1305.004 (B) AND L
    - W3 – PROVIDER IS NOT WITHIN THE LIBERTY HEALTH CARE NE
    - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.
    - U301 – THIS ITEM HAS BEEN REVIEWED ON A PREVIOUSLY SUBMITTED BILL, OR IS CURRENTLY IN PROCESS. NOTIFICATION OF DECISION HAS BEEN PREVIOUSLY PROVIDED OR WILL BE ISSUED UPON COMPLETION OF OUR REVIEW.

Issues

1. Is the claim is subject to a certified workers' compensation health care network (HCN) established under Insurance Code Chapter 1305?
2. Under what authority is this dispute decided?
3. Are the insurance carrier's reasons for denial of payment supported?
4. What is the recommended payment for the services in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier's position statement asserts the disputed services "were denied as performed at a facility that does not participate in the Liberty HCN"

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

   To support that the injured employee is enrolled in an HCN established in accordance with Insurance Code Chapter 1305, the insurance carrier submitted a copy of an employee notification of network requirements. However, review of the submitted notice finds that the employee acknowledgement page is unsigned.

   Insurance Code §1305.005(d)(1) requires that the employer shall "obtain a signed acknowledgment from each employee . . . that the employee has received information concerning the network and the network's requirements." Based on the information presented to MFDR, the respondent has not met this requirement.

   Insurance Code §1305.005(h) requires that "An injured employee is not required to comply with the network requirements until the employee receives the notice under Subsection (d), (e), or (g). An insurance carrier that establishes or contracts with a network is liable for the payment of medical care under the requirements of Title 5, Labor Code, for an injured employee who does not receive notice until the employee receives notice of network requirements under this section."

   Based on the information submitted for review, the division finds the insurance carrier has failed to support the injured employee is enrolled in an HCN established in accordance with Insurance Code Chapter 1305 or that the injured employee must comply with such network requirements. Pursuant to Insurance Code §1305.005(h), the insurance carrier is liable for payment of medical care under the requirements of Title 5, Labor Code, for the injured employee due to failure to meet the notice requirements specified under Insurance Code §1305.005.

2. The requestor in this dispute is a hospital facility that provided emergency room services to an injured employee. The respondent asserts the claim is subject to the requirements of a certified workers' compensation health care network (HCN) established in accordance with Insurance Code Chapter 1305; although as found above, the respondent has failed to support this assertion.

   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.

3. The insurance carrier denied disputed services with adjustment reason code X397 – "PROVIDER IS NOT WITHIN THE LIBERTY HEALTH CARE NETWORK (HCN) FOR THIS CUSTOMER. TX INSURANCE CODE 1305.004 (B) AND LABOR CODE 401.011."

   The respondent's position statement asserts, "Although the injured employee was admitted through the emergency room, it is our position that the patient was very much aware of Network requirements and should have chosen an in Network facility."

   As stated above, the respondent has failed to support that the injured employee was aware of any such network requirements, as the respondent did not present any information to support they have obtained a signed acknowledgment of notification from the injured employee, as required by Insurance Code §1305.005(d).

   Regardless, Insurance Code §1305.006 (1), states that the insurance carrier is liable for emergency care out-of-network health care provided to an injured employee.

   Similarly, 28 Texas Administrative Code §134.600(c)(1) requires that the insurance carrier is liable for all reasonable and necessary medical costs relating to the health care in the case of an emergency as defined in Chapter 133.

   Moreover, 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) additionally provides that "Treatments and services for an emergency do not require preauthorization." Insurance Code §1305.351(c) further states, "A network or an insurance carrier may not require preauthorization of treatments and services for a medical emergency."

   Both Insurance Code §1305.004(a)(13) and the corresponding division rule at 28 Texas Administrative Code §133.2(5)(A) 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 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 medical record finds the provider documents that on the first date of service, before treatment, the injured employee woke with sharp pain and numbness on the bottom of both feet. The employee later became unable to walk. The record supports the employee's pain was severe. The records also note intermittent and uncontrollable shaking and spasms. The division finds the documented symptoms to be of sufficient severity that the absence of immediate medical attention could *reasonably be expected* to result in serious jeopardy to the health, bodily function, or serious dysfunction of body parts. As such, the health care provider could not have in good conscience turned the patient away without providing further evaluation and treatment. The division thus finds a medical emergency was supported at the time of treatment.

   Because a medical emergency was supported, the injured employee was not required to seek treatment from a provider under contract with or employed by the network or insurance carrier. Neither was the hospital required to seek a referral, network approval, or preauthorization before providing the emergency health care.

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

This dispute regards emergency room services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors, as published annually in the Federal Register, with modifications set out in the rules. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200 percent for the outpatient facility services in this dispute.

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 code 99285 has status indicator J2, denoting outpatient visits subject to comprehensive packaging if 8 or more hours of observation are billed. Review of the bill finds that more than 8 hours of observation were reported under HCPCS code G0378. Per Medicare payment policy, when criteria are met, all line items on the claim (excepting certain limited exclusions) are packaged together as a single comprehensive service paid under APC 8011 (Comprehensive Observation Services). The OPPS Addendum A rate is $2,222.64. This is multiplied by 60% for an unadjusted labor-related amount of $1,333.58, which is multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $1,306.11. The non-labor related portion is 40% of the APC rate, or $889.06. The sum of the labor and non-labor portions is $2,195.17. The cost of services does not exceed the threshold for outlier payment. The sum of $2,195.17 is the Medicare facility specific amount. This is multiplied by the DWC outpatient conversion factor of 200%, resulting in a reimbursement amount of $4,390.34.
- Payment for all other services on the claim is packaged with the primary comprehensive service in accordance with Medicare payment policy regarding comprehensive APCs. Reimbursement is included with payment for the primary J2 status procedure. Please see *Medicare Claims Processing Manual* Chapter 4 §10.2.3 for details.

4. The total recommended reimbursement for disputed services is $4,390.34. The insurance carrier has paid $0.00, leaving an amount due to the requestor of $4,390.34. 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 $4,390.34.

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 $4,390.34, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	June 1, 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.