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
HAND & WRIST CENTER OF HOUSTON

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
September 12, 2018

Carrier's Austin Representative
Box Number 54

MFDR Date Received
M4-19-0149-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The injured worker's medical condition has been determined to be a medical emergency as defined in the Texas Administrative Code. TITLE 28, PART 1, CHAPTER 10, SUBCHAPTER A, RULE §10.2(15)"

Amount in Dispute: $1,653.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This 1/25/18 was not emergent based on the requester's documentation. Texas Mutual believes there was ample time to obtain preauthorization, which was not done."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
January 25, 2018	Professional Medical Services	$1,653.76	$1,653.76

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing.
4. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 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.
   - 197 – PRECERTIFICATION/AUTHORIZATION ABSENT
   - 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
   - 786 – DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.

Issues

1. Was preauthorization required?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 197 – PRECERTIFICATION/AUTHORIZATION ABSENT
   - 786 – DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.

   The insurance carrier's response asserts, "Texas Mutual believes there was ample time to obtain preauthorization, which was not done."

   The division notes that "ample time to obtain preauthorization" is not listed in any division rule as a criterion for determining whether authorization is required, nor is it listed as a part of or an exception to the definition of an "emergency." In the case of an emergency, preauthorization is not required.

   28 Texas Administrative Code §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."

   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 *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 operative report finds the surgeon documented "considerable tissue necrosis" penetrating "down to the bone causing a local nidus of osteomyelitis" [area of bone infection] as well as "decaying fibers of the fdp" [flexor digitorum profundus muscle]. Cultures taken from the injury site indicated four species of oral organisms. Despite that the exploration of the wound found no *active* infection process, this could not have been determined *prior* to the surgery.

   Upon review of the submitted documentation the division finds the manifested symptoms to be of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in loss of or serious dysfunction to the employee's finger or hand and could further be expected to place the patient's health or bodily functions in serious jeopardy.

   Accordingly, the division finds the requirements of Rule §133.2(5)(A) to be met; a medical emergency is supported. As such, preauthorization of the disputed health care was not required.

   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 surgical services with reimbursement subject to the *Medical Fee Guideline for Professional Services*, 28 Texas Administrative Code §134.203, requiring the maximum allowable reimbursement (MAR) be determined by applying Medicare payment policies with modifications set out in the rule. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The DWC conversion factor is substituted to calculate the MAR. For surgery in a facility setting, the DWC 2018 conversion factor is $73.19. Reimbursement is calculated as follows:
   - Procedure code 13160, January 25, 2018, has a Work RVU of 12.04 multiplied by the Work GPCI of 1.02 is 12.2808. The practice expense RVU of 8.82 multiplied by the PE GPCI of 1.012 is 8.92584. The malpractice RVU of 2.12 multiplied by the malpractice GPCI of 0.936 is 1.98432. The sum is 23.19096 multiplied by the facility surgery conversion factor of $73.19 for a MAR of $1,697.35. Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's charge. The lesser amount is $1,653.76.
3. The total allowable reimbursement for the disputed services is $1,653.76. The insurance carrier paid $0.00. The amount due is $1,653.76. 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.

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 $1,653.76.

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 $1,653.76, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	September 28, 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.