



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

M4-19-2410-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

January 2, 2019

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."

Amount in Dispute: \$10,668.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Absent an emergency preauthorization was required but not obtained. No payment is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 26, 2018	Outpatient Hospital Services	\$10,668.01	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- Texas Insurance Code §1305.004 defines terms related to workers' compensation health care networks.
- Texas Insurance Code §1305.006 establishes insurance carrier liability for certain out-of-network health care.
- Texas Insurance Code §1305.153 sets out general provisions related to provider reimbursement.
- Texas Insurance Code §1305.351 sets out requirements for utilization review of network health care.
- 28 Texas Administrative Code §133.2 defines words and terms related to medical bill processing.
- 28 Texas Administrative Code §134.600 sets out requirements regarding authorization of health care.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
 - 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
- 18 – EXACT DUPLICATE CLAIM/SERVICE
- 736 – DUPLICATE APPEAL. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK. CALL 800-381-8067 FOR RECONSIDERATION DISCUSSION.

Issues

1. Are the services eligible for medical fee dispute resolution?
2. Is an emergency supported?
3. Was preauthorization required?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is a surgeon who provided services to an injured employee enrolled in a workers' compensation health care network certified under Texas Insurance Code chapter 1305. The requestor does not participate in the network. The provider requested medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307, pursuant to the exception provided by Insurance Code §1305.006 (1) requiring an insurance carrier that establishes or contracts with a network be liable for emergency out-of-network health care.

The division's Medical Fee Dispute Resolution (MFDR) section has authority to review such disputes in accordance with Insurance Code §1305.153(c), which 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."

This dispute is therefore reviewed in accordance with the Texas Workers' Compensation Act and division rules.

2. The requestor asserts, "The injured worker's medical condition has been determined to be a medical emergency as defined in the Texas Administrative Code."

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

Insurance Code §1305.004(a)(13) 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: (A) placing the patient's health or bodily functions in serious jeopardy; or (B) serious dysfunction of any body organ or part."

This is consonant with division Rule §133.2(5)(A), which 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 insurance carrier argues: "The requestor on 4/25/18 performed an upper extremity arterial study and billed Texas Mutual for this... if the surgery was known on 4/25/18 to be taking place on 4/26/18 then, why was the surgery not performed that same date, if it was an emergency per Rule 133.2."

However, review of the submitted evidence finds insufficient information to determine which date the surgeon learned of the severity of the necrosis or to support a delay between the date of diagnosis and surgery; the respondent has not supported that assertion.

The operative report notes a "wound ischemic breakdown volar and radial" of the index finger, remarking:

With the necrotic tissue overlying the covered pathway of the tendon that is unacceptable for tendon healing, gliding and rehabilitation and cannot continue as soon as we recognize that we are truly at the full-thickness level, which is only evident on this visit.

Nevertheless, the operative report observes, "No signs of infection yet." Moreover, the surgeon did not make any findings related to the need for haste or notation to the effect that, without swift treatment, imminent harm could occur. The medical record fails to make clear that lack of immediate medical attention would result in serious jeopardy or dysfunction to the injured employee's health, organs or body parts.

The division concludes that, while the provider did support the acuteness and severity of the condition and that the absence of medical attention could be expected to result in eventual dysfunction of the tendon or finger, the provider did not document sufficient urgency or immediate risk to support a medical emergency.

3. The insurance carrier denied disputed services with claim adjustment reason codes:

- 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
- 786 – DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.

The respondent states, "Absent an emergency preauthorization was required but not obtained."

Insurance Code §1305.351 (c) requires that, "If a network or carrier uses a preauthorization process within a network, the requirements of this subchapter and commissioner rules apply."

The division's preauthorization rule, 28 Texas Administrative Code §134.600(p)(2) states that non-emergency health care requiring preauthorization includes: "outpatient surgical or ambulatory surgical services"

The disputed services are outpatient surgical procedures. As stated above, the submitted records do not support a medical emergency. Accordingly, preauthorization was required. The carrier's denial reasons are thus supported.

4. Rule §134.600(c)(1) requires insurance carriers to be liable for the cost of non-emergency health care only when "preauthorization of any health care listed in subsection (p) ... was approved prior to providing the health care."

In summary of the findings above, a medical emergency was not supported; preauthorization was therefore required to perform outpatient surgery, but not obtained for the disputed services. Consequently, the insurance carrier is not liable for payment. Reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____	<u>Grayson Richardson</u>	<u>March 22, 2019</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 DWCO45M) in accordance with the form's instructions. The division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 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.