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
ERICK SANTOS, MD

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-19-3078-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
February 8, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The injured worker was originally pre-authorized to have a meniscectomy to the right knee as a medial meniscus tear was evidenced in an MRI… Once the scope was introduced… it was noted that the meniscus was in fact, not torn, however medial plica was visualized…. The medical provider performed the synovectomy because it was medically appropriate at the time of the surgery. The previously approved meniscectomy was not performed because after visualization (during the arthroscopic procedure of the knee) it was NOT medically appropriate to perform a meniscectomy…. I am requesting that you review the operative report and allow for the actual, medically appropriate procedure that was performed."

Amount in Dispute: $2,752.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the facility did not bill for the procedure codes and/or services that were preauthorized."

Response Submitted by: State Office of Risk Management (SORM)

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 14, 2018	Outpatient Hospital Services	$2,752.00	$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

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 §133.240 sets out requirements regarding medical bill payments and denials.
4. 28 Texas Administrative Code §134.600 sets out requirements regarding authorization of health care.
5. Insurance Code Chapter 1305 sets out requirements for certified workers' compensation health care networks.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

- 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
- 1241 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION/REQUEST FOR SECOND REVIEW.

Issues

1. Is this dispute subject to procedures for resolution of certified workers' compensation network claims?
2. Does the response raise new defenses that were not presented to the health care provider before MFDR?
3. Did the insurance carrier issue additional payment after reconsideration or appeal?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent asserts that "this appears to be a network dispute whereas the Division does not have jurisdiction."

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

   Rule §133.240(e)(1) requires the insurance carrier to send an explanation of benefits (EOB) in accordance with Rule §133.240(f), if submitted in paper form, to the health care provider when the insurance carrier makes or denies payment on a medical bill.

   Rule §133.240(f)(15) requires paper EOBs to include the workers' compensation network name (if applicable).

   Review of the submitted EOBs finds no network name or any indication the claim is subject to a certified workers' compensation HCN established under Insurance Code Chapter 1305. Nor did the response contain any evidence to support the injured worker is enrolled in a certified workers' compensation network or that the health care provider is contracted with the alleged network.

   The division thus concludes the respondent has not met the requirements to support the dispute is subject to HCN procedures for resolving complaints or disputes. Consequently, this dispute is eligible for review by the division's MFDR section in accordance with Texas Labor Code §413.031 and applicable division rules.

2. The insurance carrier response raises new defenses that were not presented to the health care provider before the filing of the request for medical fee dispute resolution.

   Rule §133.307(d)(2)(F) requires 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."

   The insurance carrier's failure to give notice to the health care provider of specific codes or explanations for payment reduction or denial, as required by Rule §133.240, constitutes grounds for the division to find a waiver of defenses during Medical Fee Dispute Resolution — and the division finds such a waiver here.

   Consequently, the division concludes the insurance carrier has waived the right to raise such new defenses during MFDR. Any such new defenses or denial reasons will not be considered in this review.

3. The insurance issued an EOB after reconsideration with claim adjustment code W3 – "Additional payment made on appeal/reconsideration." Review of the submitted information finds that no payment was made during initial bill review nor any additional payment made after reconsideration. The insurance carrier paid $0.00 for the disputed services. The division concludes this payment adjustment code is not supported.

4. This dispute regards outpatient surgical services subject to the requirements of Rule §134.600(c)(1), which requires the insurance carrier be liable for all reasonable and necessary medical costs relating to health care listed in subsection (p) only in an emergency or when preauthorization was approved prior to providing the health care.

   Rule §134.600(p)(2) states that non-emergency health care requiring preauthorization includes outpatient surgery.

   Review of the submitted information finds the surgeon sought and received preauthorization to perform procedure code 29880 – "Arthroscopy, knee, surgical; with meniscectomy."

The requestor states:

> The injured worker was originally pre-authorized to have a meniscectomy to the right knee as a medial meniscus tear was evidenced in an MRI… Once the scope was introduced… it was noted that the meniscus was in fact, not torn, however medial plica was visualized…. The medical provider performed the synovectomy because it was medically appropriate at the time of the surgery. The previously approved meniscectomy was not performed because after visualization (during the arthroscopic procedure of the knee) it was NOT medically appropriate to perform a meniscectomy….

SORM responds that "the facility did not bill for the procedure codes and/or services that were preauthorized."

Review of the medical bill finds the disputed services were billed using procedure codes 11900-59, 15271-59, and 29876 – "Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments." None of the billed procedure codes are present on the preauthorization approval letter.

Because the disputed services were not preauthorized, the insurance carrier is not liable for payment in accordance with rule §134.600(c)(1). Reimbursement cannot be 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 emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available 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 not established that additional 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

	Grayson Richardson	March 8, 2019
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 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.