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
MEMORIAL HERMANN HOSPITAL SYSTEM

Respondent Name
XL INSURANCE AMERICA, INC.

MFDR Tracking Number
M4-19-4561-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 20, 2019

Response Submitted By
Flahive, Odgen & Latson, Attorneys at Law, PC

REQUESTOR'S POSITION SUMMARY

"It was denied 'for absence of precertification/authorization.' I submitted an appeal letter… due to the patient coming into the Emergency Room…"

RESPONDENT'S POSITION SUMMARY

"the claimant is in the First Health Coventry certified healthcare network… Accordingly, the provider's request for medical fee dispute resolution is not eligible for review by the Medical Review Division…"

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 14, 2018	Emergency Room Services	$29,253.50	$225.08

AUTHORITY

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 §133.2 defines 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 hospital facility fee guideline for outpatient services.
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:
   - 197 – PRECERTIFICATION/AUTHORIZATION ABSENT
   - 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.
   - 1014 - The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Is this dispute eligible for review?
2. Did the respondent waive the right to wave new denial reasons or defenses?
3. Was precertification/authorization required?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The response asserts, “the claimant is in the First Health Coventry certified healthcare network… Accordingly, the provider’s request for medical fee dispute resolution is not eligible for review by the Medical Review Division…”

   Review of records maintained by the division finds no notification to the division the insurance carrier has enrolled the injured employee in a certified workers’ compensation health care network (HCN) established in accordance with Insurance Code Chapter 1305. The response does not include any documentation to support the injured employee is enrolled in a certified HCN.

   Based on the information presented for review, and information known to the division, the division concludes the respondent failed to support the injured employee is enrolled in a certified HCN. Consequently, this dispute is eligible for medical fee dispute resolution.

2. The respondent raises new denial reasons and defenses in their position statement regarding a lien that were not presented to the health care provider before the filing of the medical fee dispute request. Further, no documentation was provided to support such a lien.

   As stated above, 28 Texas Administrative Code §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."

   Accordingly, the division concludes the respondent has waived the right to raise any such defense and such newly raised denial reasons or defenses shall not be considered in this review.

3. The insurance carrier denied disputed services with claim adjustment reason code 197 – “PRECERTIFICATION/ AUTHORIZATION ABSENT”

   28 Texas Administrative Code §134.600(c)(1)(A) requires that the carrier is liable for all reasonable and necessary medical costs relating to the health care in “an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions)”

   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 rule does not require the patient to actually *be* in jeopardy or *suffer* serious dysfunction. It is only required that the patient manifest acute *symptoms* of sufficient severity (including severe pain) that turning the patient away, without evaluation or treatment, could *be expected* (prior to rendering care and *without benefit of hindsight*) to result in serious jeopardy or dysfunction if treatment were not provided.

   Review of the medical records finds that the elements of a medical emergency are documented consistent with the definition in Rule §133.2. Accordingly, it was not required that the provider obtain precertification or authorization before rendering treatment. The insurance carrier’s denial reasons are thus not supported. Consequently, the disputed services will be reviewed for reimbursement in accordance with division guidelines.

4. This dispute regards Emergency Room services subject to DWC's *Hospital Facility Fee Guideline*, Rule §134.403, which requires the maximum allowable reimbursement (MAR) be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors modified by DWC rules.

   Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for the disputed hospital facility services.

   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 73700 represents a CT scan. This code is assigned APC 5522 with OPPS Addendum A rate of $114.46. This is multiplied by 60% for an unadjusted labor amount of $68.68, and in turn multiplied by the facility wage index of 0.972 for an adjusted labor amount of $66.76. The non-labor portion is 40% of the APC rate, or $45.78. The cost of services does not exceed the threshold for outlier payment. The sum of the labor and non-labor portions is the Medicare facility specific amount of $112.54. This is multiplied by 200% for a MAR of $225.08.

   The total recommended reimbursement for the disputed services is $225.08. The insurance carrier paid $0.00. The amount due is $225.08. 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 findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the division finds that additional payment is due. As a result, the amount ordered is $225.08.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, the division finds the requestor is entitled to additional reimbursement. The division hereby ORDERS the respondent to remit to the requestor $225.08, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	July 19, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). 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 field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute 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.