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**
ST JOSEPH MEDICAL CENTER

**Respondent Name**
TEXAS MUTUAL INSURANCE COMPANY

**MFDR Tracking Number**
M4-20-0228-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
September 25, 2019

**Response Submitted By**
Texas Mutual

## *REQUESTOR'S POSITION SUMMARY*

The requestor did not submit a position statement for review with their dispute resolution request.

## *RESPONDENT'S POSITION SUMMARY*

"Texas Mutual claim… is in the WorkWell network. (Attachment)…
The procedure was essentially debridement of an area showing no infection…
The documentation does not mention necrosis. The surgeon documented finding no purulence in the wound."

## *SUMMARY OF DISPUTE*

| Dates of Service | Disputed Services | Dispute Amount | Amount Due |
|---|---|---|---|
| March 25, 2019 | Outpatient Hospital Services | $2,586.61 | $2,586.61 |

## *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 (DWC).

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 defines words and terms related to medical bill processing.
4. 28 Texas Administrative Code §134.600 sets out requirements regarding authorization of health care.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.
   - 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
   - 786 – DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.
   - 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS.
   - 895 – 133.210 REQUIRES ITEMIZED STATEMENT FOR HOSPITAL SERVICES.
   - 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2

- 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.
- DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (800) 859-5995 X3994.
- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

## Issues

1. Are the services subject to a certified network established under Texas Insurance Code Chapter 1305?
2. Was a medical emergency documented?
3. Is the requestor entitled to additional reimbursement?

## Findings

1. The respondent asserts, "Texas Mutual claim… is in the WorkWell network. (Attachment)…"

   The submitted attachment did not support that the injured employee's claim is in the WorkWell network. The name of the alleged network is not mentioned on the submitted document. The document contained no information to support that the injured employee's claim is subject to the provisions of a certified workers' compensation HCN established in accordance with Insurance Code Chapter 1305.

   Labor Code §402.082(a)(3) requires DWC to maintain information on every compensable injury as to the "identification of whether the claimant is receiving medical care through a workers' compensation health care network certified under Chapter 1305, Insurance Code." Based on information maintained by the division, the injured employee was not enrolled in the alleged network on the date of service.

   28 Texas Administrative Code Chapter 134, Subchapter I, sets out reporting requirements for all insurance carriers for each medical bill; including Rule 28 TAC §134.807(f)(7), which requires carriers to report whether services were performed within a certified workers' compensation HCN or under a contractual fee arrangement — for each medical bill on a workers' compensation claim. The insurance carrier has not previously reported to DWC that these services were performed within a certified HCN or under a contractual fee arrangement.

   Rule 28 Texas Administrative Code §133.240(f)(15) requires the paper form of any explanation of benefits (EOB) to include the "workers' compensation health care network name (if applicable);" however, the submitted EOBs do not mention the name of any network.

   To the contrary, the EOBs state, "Insurance carrier payment to the health care provider shall be according to Division medical policies and fee guidelines in effect on the date(s) of service(s)."

   The respondent failed to support the position that the disputed health care is subject to the provisions of a workers' compensation HCN established in accordance with Texas Insurance Code Chapter 1305. The division thus concludes Insurance Code Chapter 1305 is not applicable to this dispute. Accordingly, this dispute is eligible for review by MFDR consistent with the Texas Labor Code and DWC rules.

2. 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.
   - 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2

   28 Texas Administrative Code §134.600(c)(1)(A), requires the insurance carrier to be 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)." Preauthorization is *not required* in the case of an emergency.

   28 TAC §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 submitted medical records support the patient exhibited symptoms of pain, stiffness, deformity and swelling, with diagnoses of deep space bacterial infection and acute osteomyelitis of the hand.

The records state "the injured workers' medical condition has been determined to be a medical emergency as defined in the Texas Administrative Code…" The perioperative record describes the purpose of the surgery as to debride and dress open osteomyelitis distal phalanx of the left thumb. It assesses a skin abnormality stating, "operative site not intact." The operative report states, "the essence of this case is a joint and bone infection." That report describes cleaning "both bone surfaces thoroughly" with curette and rongeur followed by scrubbing with sponges, "dissected out all tissue pockets" and "scrubbed in every pocket sterile saline sponges."

Based on the manifested symptoms, the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the employee's health or bodily functions, or serious dysfunction of a body part or organ. DWC therefore concludes a medical emergency is supported. Because an emergency existed at the time of treatment, preauthorization was not required. The insurance carrier's denial reasons are not supported. The disputed services will therefore be reviewed for payment consistent with DWC rules and fee guidelines.

3. This dispute regards outpatient facility 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 is calculated as follows:

   - Procedure codes J1100, J2250, J2270, J2270, J3010 have status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
   - Procedure code 26236 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5112. The OPPS Addendum A rate is $1,313.34, which is multiplied by 60% for an unadjusted labor amount of $788.00, and in turn multiplied by the facility wage index of 0.9754 for an adjusted labor amount of $768.62. The non-labor portion is 40% of the APC rate, or $525.34. The sum of the labor and non-labor portions is the Medicare facility specific amount of $1,293.96. This is multiplied by 200% for a MAR of $2,587.92.

   The total recommended reimbursement for the disputed services is $2,587.92. The insurance carrier paid $0.00. The requestor is seeking additional reimbursement of $2,586.61. This amount is recommended.

## Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of the division is to adjudicate payment following Texas laws and DWC 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 requestor has not established that additional payment is due. As a result, the amount ordered is $2,586.61.

## *ORDER*

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $2,586.61, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

| | Grayson Richardson | October 25, 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 28 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.