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
EMPLOYERS PREFERRED INSURANCE COMPANY

MFDR Tracking Number
M4-20-0450-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
October 21, 2019

Response Submitted By
EIG Services, Inc.

REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position statement for consideration in this review.

RESPONDENT'S POSITION SUMMARY

"Employers Preferred Insurance Company maintains its denial of the treatment and surgery rendered for the date of service 8/16/2019 as the treatment was no authorized or approved."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 16, 2019	Outpatient Hospital Services	$5,166.65	$5,166.65

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) in Title 28, Part 2 of the Texas Administrative Code.

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. Texas Labor Code §408.021 establishes an injured employee's entitlement to medical benefits.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 4915 - THE CHARGE FOR THE SERVICES REPRESENTED BY THE REVENUE CODE ARE INCLUDED/BUNDLED INTO THE TOTAL FACILITY PAYMENT AND DO NOT WARRANT A SEPARATE PAYMENT OR THE PAYMENT STATUS INDICATOR DETERMINES THE SERVICE IS PACKAGED OR EXCLUDED FROM PAYMENT.
   - 6522 – WE NEED THE FOLLOWING INFORMATION TO DECIDE WHETHER TO PAY FOR THESE SERVICES (SEE ADDITIONAL OBJECTIONS)
   - 6532 – ABSENCE OF, OR EXCEEDS, PRE-CERTIFICATION/AUTHORIZATION.
   - 6533 – PAYMENT IS SUSPENDED PENDING UR TO DETERMINE IF TREATMENT IS "REASONABLE AND NECESSARY". SEE UR LETTER SENT UNDER SEPARATE COVER.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

- P13 – PAYMENT REDUCED OR DENIED BASED ON WORKERS' COMPENSATION JURISDICTIONAL REGULATIONS OR PAYMENT POLICIES.
- 5280 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION
- 6529 – SERVICES WERE NON-CERTIFIED BY UR. (SEE UR LETTER AND EXAMINER LETTER SENT UNDER SEPARATE COVER).
- 6532 – ABSENCE OF, OR EXCEEDS, PRE-CERTIFICATION/AUTHORIZATION.
- 6538 – CONSIDER THIS CONTINUING OBJECTION TO ALL FURTHER SERVICES.

Issues

1. Was pre-certification or authorization required?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 6532 – ABSENCE OF, OR EXCEEDS, PRE-CERTIFICATION/AUTHORIZATION.
   - 6533 – PAYMENT IS SUSPENDED PENDING UR TO DETERMINE IF TREATMENT IS "REASONABLE AND NECESSARY". SEE UR LETTER SENT UNDER SEPARATE COVER.
   - 6529 – SERVICES WERE NON-CERTIFIED BY UR. (SEE UR LETTER AND EXAMINER LETTER SENT UNDER SEPARATE COVER).
   - 6532 – ABSENCE OF, OR EXCEEDS, PRE-CERTIFICATION/AUTHORIZATION.

   DWC notes the respondent did not present a copy of the alleged utilization review (UR) letter or report for consideration in this review. This denial reason is not supported.

   28 Texas Administrative Code §134.600(p)(2) requires preauthorization for non-emergency outpatient surgery.

   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 injured employee suffered a traumatic crushing injury to the hand nearly two weeks before the date of exam. The employee presented to the hospital with symptoms of pain, swelling and discoloration of the hand. Upon examination and evaluation, the hospital discovered a metacarpal shaft fracture described as "highly displaced long MC spiral fx." The documentation notes: "deficiency of function in body areas of right upper extremity and left upper extremity." The treatment plan observes specifically that "the body region is at this point no longer normal to start with…" and the surgeon's comments note: "malunion" of the fracture with the goal of surgery to "repair to anatomically correct," noting also that "Time lost since injury will accrue towards greater ultimate stiffness and so he will have to work extra hard to catch up in therapy."

   Because existing dysfunction of the extremity and malunion of the fracture is documented, based on the medical record, the absence of immediate medical attention could reasonably be expected to result in serious dysfunction to a body part (the hand) if the fracture were not corrected and the metacarpal was allowed to knit together further in the misaligned state. Accordingly, DWC finds that a medical emergency existed at the time of treatment.

   Because a medical emergency was supported at the time of treatment, pre-certification or authorization of the service was not required. The insurance carrier's denial reasons are not supported. Consequently, the disputed services will be reviewed for payment consistent with DWC rules and fee guidelines.

2. This dispute regards outpatient facility services subject to DWC's *Hospital Facility Fee Guideline*, 28 TAC §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 28 TAC §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 26615 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 5113. The OPPS Addendum A rate is $2,623.34, which is multiplied by 60% for an unadjusted labor amount of $1,574.00, and in turn multiplied by facility wage index 0.9754 for an adjusted labor amount of $1,535.28. The non-labor portion is 40% of the APC rate, or $1,049.34. The sum of the labor and non-labor portions is the Medicare facility specific amount of $2,584.62. This is multiplied by 200% for a MAR of $5,169.24.
- Payment for all other services on the bill is packaged with the primary comprehensive J1 service per Medicare policy regarding comprehensive APCs. See *Medicare Claims Processing Manual* Chapter 4 §10.2.3 for details.

The total recommended reimbursement for the disputed services is $5,169.24. The insurance carrier paid $0.00. The requestor is seeking additional reimbursement of $5,166.65. 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 established that additional payment is due. As a result, the amount ordered is $5,166.65.

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 $5,166.65, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	November 15, 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.