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
M4-20-1475-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 11, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Effective March 1, 2008, the State of Texas revised its Medical Fee Guidelines governing workers compensation reimbursement of medical services. The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code. This Request for Reconsideration of adjusted and/or disputed amounts is due to: Per page 22 of Medical records, this service was a medical emergency as defined by the Texas Administrative code. Please process & pay."

Amount in Dispute: $9,144.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is a network claim. (Attachment). Treatment was rendered at ST. JOSEPH MEDICAL CENTER per documentation and billing submitted to Texas Mutual on 12/27/2019. Audit staff reviewed documents and did not locate preauthorization for outpatient surgical procedure, the bill was denied as no preauthorization was obtained. Additional review of the claim and medical records submitted confirms the treating/rendering Dr. Mark Henry saw patient on 12/16/19-12/17/2019, it appears per the documentation submitted the surgical procedure was planned, therefore not considered emergent as there was a 2-3 day gap between the Office Visit and Surgical date. The provider did not follow network preauthorization guidelines for services/procedures rendered in a setting or place of service other than the doctor's office (POS 11). Network preauthorization guidelines can be located at…"

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
December 19, 2019	Outpatient Facility Charges	$9,144.01	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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. Texas Insurance Code §1305 applicable to Health Care Certified Networks.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - CAC-W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
    - CAC-Q93 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
    - CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
    - DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION.
    - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
    - 786 – DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.

Issue(s)

1. Did the out-of-network healthcare provider meet the requirements of Chapter §1305.006?
2. Is this dispute eligible for medical fee dispute resolution (MFDR) pursuant to 28 TAC §133.307?
3. What is the dispute resolution path for disputes that fall under Chapter 1305?

Findings

1. The requestor billed for outpatient facility charges to an injured employee enrolled in a certified healthcare network. The insurance carrier's response indicates that this is a network claim and included an attachment to support the network enrollment for the injured employee. The requestor seeks a decision from the Division's medical fee dispute resolution (MFDR) section as an out-of-network healthcare provider, indicating this was an emergent procedure.

    The insurance carrier denied/reduced the disputed charges with denial reason code "CAC-197 and 786."

    The requestor filed this medical fee dispute to the Division requesting resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation to resolve matters involving employees enrolled in a certified health care network, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 and limited application of Texas Labor Code statutes and rules, including 28 Texas Administrative Code §133.307.

    Chapter §1305.006 outlines the insurance carrier's liability for out-of-network healthcare and states, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:
    (1) <u>emergency care;</u>
    (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
    (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103.

    28 TAC §133.2 defines an emergency as, "(5) Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is 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; (B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person."

    Review of the medical records document that the injured employee was seen by Dr. Mark Henry on 12/16/19-12/17/2019 and scheduled an outpatient procedure on December 19, 2019. The DWC finds that the medical records do not document an "emergency" as defined pursuant to 28 TAC §133.2. As a result, the disputed services were rendered by an out-of-network health care provider to an in-network injured employee.

2. The requestor billed for outpatient facility charges rendered on December 19, 2019. The insurance carrier denied the disputed services with denial reason code(s): "CAC-197 and 786." The issue is whether the out of network healthcare provider was required to obtain preauthorization through the network for non-emergency services. The DWC finds that adjudicating the disputed service would involve enforcing a law, regulation, or other provision for the disputed service(s), provided to an in-network injured employee. The DWC finds the disputed services are not under the jurisdiction of the DWC and therefore, are not eligible for medical fee dispute resolution pursuant to 28 TAC §133.307.

3. The DWC finds that the disputed services were rendered to an in-network injured employee. The TDI rules at 28 TAC §§10.120 through 10.122 address the submission of a complaint by a health care provider to the Health Care Network. The DWC finds that the disputed services may be filed to the TDI Complaint Resolution Process if the health care provider or facility is dissatisfied with the outcome of the network complaint process. The complaint process outlined in TIC Subchapter I, §1305.401 - §1305.405 and may be the appropriate administrative remedy to address matters related to health care certified networks.

FINDINGS

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC §413.031, the DWC has determined that the requestor is not eligible for MFDR under 28 TAC §133.307.

Authorized Signature

______________________________	______________________________	August 13, 2020
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 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

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 instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed, or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 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.