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

MFDR Tracking Number
M4-20-1624-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 2, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DOS not paid."

Amount in Dispute: $967.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…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..."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 2019	Outpatient hospital services	$967.03	$967.00

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. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. 28 TAC §133.2 defines emergency.
4. Texas Insurance Code §1305.006 defines the insurance carrier's liability for out-of-network healthcare.
5. Texas Insurance Code §1305. 153 out guidelines for out-of-network claim payment.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization notification absent

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 796 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract.

Issues

1. Is the insurance carrier's position supported?
2. What rule is applicable to reimbursement?
3. Is additional payment due?

Findings

1. Review of the submitted documentation found the claimant was seen in the physicians' office on December 16, 2019 and outpatient surgery was scheduled for the same day. The scheduled procedure was a finger repeat debridement and dress open of trauma wound.

   28 TAC §133.2 (5) (A) defines an 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 placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction of any body organ or part.

   The treating physician indicated the urgent need of the procedure was based on "a time based elimination of bacteria with antibiotics from the state of the original presentation with heavy contamination and infection occurring."

   Based on the above, the definition of "emergency" is met. The insurance carrier's position is not supported. The denial for lack of pre-authorization is not supported. The network issue is discussed in the following paragraphs.

   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, emergency care.

   The DWC MFDR section may address disputes involving health care provided to an injured employee enrolled in an HCN, only if the out-of-network services were provided pursuant Chapter §1305.006.

   The disputed services are eligible for medical fee dispute resolution and are reviewed pursuant to Texas Insurance Code §1305.153(c) which states Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation. The applicable fee guideline is found in 28 TAC §134.430 and the calculation is shown below.

2. 28 TAC §134.430 states outpatient hospital services are reimbursed based on the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors multiplied by 200 percent unless a separate request for implants is made. Review of the submitted medical bill found implants are were not provided. The fee calculation is as follows:
   - Procedure code 11043 has status indicator T and is assigned APC 5053. The OPPS Addendum A rate is $482.89. This is multiplied by 60% for an unadjusted labor amount of $289.73, in turn multiplied by facility wage index 1.0021 for an adjusted labor amount of $290.34.

     (Please note: Medicare updates Wage Index factors every October 1st, effective for the Federal Fiscal Year – not the calendar year.)

The non-labor portion is 40% of the APC rate, or $193.16. The sum of the labor and non-labor portions is $483.50. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount is $483.50. This is multiplied by 200% for a MAR of $967.00.

- Procedure code J3010 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J2250 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J1885 has status indicator N reimbursement is included with payment for the primary services.
- Procedure code J1100 has status indicator N reimbursement is included with payment for the primary services.

3. The total recommended reimbursement for the disputed services is $967.00. The insurance carrier paid $0.00. The amount due is $967.00. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC 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 payment is due. The amount ordered is $967.00.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $967.00, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		March 31, 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 Rule §133.307, effective May 31, 2012, *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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

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