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 Co

MFDR Tracking Number
M4-21-0338-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 27, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This was a medical emergency, therefore, authorization is not needed."

Amount in Dispute: $2,714.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Absent an emergency; preauthorization is required for non-emergency treatment. The provider did not fully comply with Rule 134.600."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 15, 2020	Outpatient Hospital Services	$2,714.30	$2,714.20

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 §134.600 sets out requirements of prior authorization.
3. 28 Texas Administrative Code §134.430 sets out the fee guidelines for outpatient services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P4 – Workers compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 197 – Precertification/authorization/notification absent

- 225 – The submitted documentation does not support the service being billed. We will re-evaluated this upon receipt of clarifying information
- 889 – Service was provided prior to carrier's date of injury
- 899 – Documentation and file review does not support an emergency in accordance with Rule 133.2
- D27 – Provider not approved to treat Workwell, Tx network claimant. For network information call 844-859-5995 x 3994
- CAC-243 – Service not authorized by network/primary care providers

Issues

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

Findings

1. The requestor is seeking reimbursement of outpatient medical services rendered July 15, 2020. The insurance carrier denied the disputed service with several reasons as discussed below.

   - Service was provided prior to the carrier's date of injury. Review of the submitted records found the reported date of injury was the same as the date services were rendered. This denial will not be considered.

   - Services were non-compensable. 28 TAC §133.307 (d) (H) states in pertinent part, If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements). Review of the submitted medical records found no PLN as required by rule. This denial will not be considered.

   - Health care provider not authorized to treat network claimant. Insufficient evidence was found to support the claimant was enrolled in a certified health network. This denial will not be considered.

   - The last denials were for lack of prior authorization, definition of emergency not met. The requestor indicated this was an emergent medical problem. The respondent stated definition of emergency not met, prior authorization was required. Review of the submitted medical records found the injured worker was injured and seen in Beaumont by a physician who found the injury had left the injured body part unable to function normally.

     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.

     Review of the history and physical report from Dr. Mark Henry on the same day the injury occurred indicates the injured body part was not functioning normally. The insurance carriers' denial for definition of emergency not met is not supported. This denial will not be considered.

   - In addition to the lack of emergency not met, the insurance carrier used this denial to state prior authorization was required. 28 TAC §134.600 (c) states in pertinent part the insurance carrier is liable for all reasonable and necessary medical costs relating to the health care resulting from an emergency. Based on the above the disputed service will be reviewed per applicable fee guideline.

2. 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

28 TAC 134.403 (f) states in pertinent part the reimbursement calculation used for establishing the MAR shall be 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 as published annually in the *Federal Register.*. The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent when a separate request for implant reimbursement is not made and 108 percent when separate reimbursement for implants is made.

The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non-labor portion determines the Medicare specific amount. Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

- Procedure code 11043 is bundled into comprehensive rate for J1 procedure 26418.
- Procedure code 26418 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 $1,355.39. This is multiplied by 60% for an unadjusted labor amount of $813.23, in turn multiplied by facility wage index 1.0021 for an adjusted labor amount of $814.94.

  The non-labor portion is 40% of the APC rate, or $542.16.

  The sum of the labor and non-labor portions is $1,357.10.

  The Medicare facility specific amount is $1,357.10.

  This is multiplied by 200% for a MAR of $2,714.20.
- Procedure code J1885 has 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.

3. The total recommended reimbursement for the disputed services is $2,714.20. The insurance carrier paid $0.00. The amount due is $2,714.20. 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. As a result, the amount ordered is $2,714.20.

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 $2,714.20, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		November 24, 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.