Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TOMBALL REGIONAL HOSPITAL

Respondent Name
AMERICAN HOME ASSURANCE COMPANY

MFDR Tracking Number
M4-06-1100-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 7, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "PPO Dscnt not applcble in cnjnction w/other reduction per TAC Rule 134.202(d)"

Amount in Dispute: $40.09

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After further review of this request, no additional payment was recommended."

Response Submitted by: Hoffman Kelley LLP, 400 West 15th Street, Suite 1520, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 19, 2005	Outpatient Hospital Services	$40.09	$40.09

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §133.304 sets out the procedures for medical payments and denials.
3. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 426 – REIMBURSED TO FAIR AND REASONABLE.
   - W10 – NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINE. REIMBURSEMENT MADE BASED ON INSURANCE CARRIER FAIR AND REASONABLE
   - 150 – PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.

Issues

1. Did the explanations of benefits include the correct payment exception codes required by Division instructions?
2. Are the disputed services subject to a negotiated or contracted fee amount?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. Former 28 Texas Administrative Code §133.304(c), effective July 15, 2000, 25 *Texas Register* 2115, required that "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as "not sufficiently documented" or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section. The insurance carrier shall maintain documentation of the date it sent the explanation of benefits, and shall either maintain a copy of the explanation of benefits or be able to electronically reproduce it. The explanation of benefits may be printed on the insurance carrier's letterhead but must include all language required by the Commission." At the time the insurance carrier made payment on the medical bill for the services in dispute, the Commission [now the Division] instructions for form TWCC-62 (explanation of benefits) required the insurance carrier to report the American National Standards Institute (ANSI) Claim Adjustment Reason Codes. Review of the submitted explanations of benefits finds no ANSI claim adjustment reason code related to reduction of payment due to a negotiated fee or contracted amount or to participation in a participating provider organization (PPO) network. The insurance carrier has not supported the use of the correct payment exception codes required by Division instructions. The explanation of benefits does not include all language required by the Division. The Division therefore finds that the insurance carrier has not met the requirements of §133.304(c).

2. The submitted explanations of benefits (EOB) refer to "Preferred Provider Organization: PPONEXT/ROCKPORT." Additionally the EOBs indicate that a PPO reduction was deducted from the provider payment, over and above the bill review reductions, for an additional amount of $40.09. The requestor's position statement asserts that "Tomball Regional Hospital (TRH) has no contracts with any networks regarding workers' compensation claims. TRH has no negotiated/contracted agreement with the carrier. A PPO discount is not applicable." Review of the submitted information finds no documentation to support a negotiated or contracted fee agreement between the health care provider and the insurance carrier, American Home Assurance Company. No documentation was found to support that the health care provider had a contracted fee agreement with PPONext/Rockport, or other participating provider organization or network. No documentation was found to support that the insurance carrier, American Home Assurance Company, had been granted access to the alleged contracted fee agreement between the health care provider and a third party. The insurance carrier has not supported this payment reduction reason.

3. This dispute involves the outpatient hospital radiology services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

4. Former 28 Texas Administrative Code §133.304(i), effective July 15, 2000, 25 *Texas Register* 2115, requires that "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall: (1) develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement." The requestor's position statement asserts that "The insurance carrier has not provided the proper payment exception code in this instance, and is obligated to pay fair and reasonable compensation in accordance with §413.011 of the Texas Labor Code and commission Rule 133.304." The insurance carrier made two payment reductions on the EOB. The insurance carrier first made a Bill Review Reduction in the amount of $1,435.85, resulting in a Bill Review Allowance of $572.65 based on claim adjustment codes W10 – "NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINE. REIMBURSEMENT MADE BASED ON INSURANCE CARRIER FAIR AND REASONABLE"; and 426 – REIMBURSED TO FAIR AND REASONABLE." The requestor does not dispute the insurance carrier's determination of a fair and reasonable reimbursement amount according to the methodology chosen by the insurance carrier. These claim adjustment codes are supported. Based on the information presented for consideration in this review, the Division finds that $572.65 is a fair and reasonable payment amount for the services in dispute.

   However, the requestor is disputing the additional PPO reduction taken above and beyond the insurance carrier's initial determination of the fair and reasonable reimbursement amount. According to the requestor's table of disputed services, the amount in dispute is $40.09. The amount of the additional PPO reduction from the EOB is $40.09. As stated above, the Division has found that the insurance carrier did not include the correct payment exception codes on the EOB and did not include all language required by the Division, thereby failing to meet the requirements of §133.304(c). Furthermore, the Division has found that the respondent failed to support a negotiated or contracted rate. Accordingly, the additional PPO reduction of $40.09, as indicated on the EOB, is not supported. The recommended reimbursement amount is $572.65.

5. The total recommended payment for the services in dispute is $572.65. This amount less the amount previously paid by the insurance carrier of $532.56 leaves an amount due to the requestor of $40.09. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $40.09.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $40.09 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	August 29, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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