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
HOUSTON NORTHWEST MEDICAL CENTER

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-10-5131-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 29, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim has been reimbursed; however, it was not processed according to the Acute Care Hospital Fee Guidelines set forth by the TWCC."

Amount in Dispute: $147.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 29, 2009	Outpatient Hospital Services	$147.16	$101.77

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 §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.
4. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on August 24, 2010. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - BL – [no description or explanation of this denial reason code was found with the submitted materials.]
   - 16 – [no description or explanation of this denial reason code was found with the submitted materials.]
   - 29 – (29) THE TIME LIMIT FOR FILING HAS EXPIRED.
   - BL – TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A REC
   - BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL.
   - BL – ADDITIONAL ALLOWANCE IS NOT RECOMMENDED AS THIS CLAIM WAS PAID IN ACCORDANCE WITH STATE GUIDELINES, USUAL/CUSTOMARY POLICIES, OR THI
   - BL – (29) THIS LINE WAS INCLUDED IN THE RECONSIDERATION OF THIS PREVIOUSLY REVIEWED BILL.

Issues

1. Did the respondent support the insurance carrier's reasons for reduction or denial of services?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
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. The insurance carrier reduced or denied disputed services with reason code 29 – "(29) THE TIME LIMIT FOR FILING HAS EXPIRED." Documentation supports that this denial was in relation to a request for reconsideration of a previous bill that had been timely submitted to the carrier for consideration. The insurance carrier's denial reason is not supported.
2. Review of the submitted documentation finds no documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. No indication was found on the submitted explanations of benefits that the insurance carrier reduced or denied payment for the services in dispute based on a contractual fee arrangement. No documentation was found of a direct contract between the insurance carrier and the health care provider. The requestor alleges that it has a contract with a third party voluntary or informal health care network. However, no documentation was found to support that the insurance carrier, New Hampshire Insurance Company, was contracted with the alleged network. No documentation was found to support that the insurance carrier had been granted access to the contractual fee arrangement between the health care provider and the alleged network. No documentation was found to support that the health care provider had been provided any notice that the insurance carrier had been granted access to the health care provider's contractual fee arrangement with the alleged network as required by 28 Texas Administrative Code §133.4, effective July 27, 2008, 33 *Texas Register* 5701, applicable to services rendered between August 1, 2008, and December 31, 2010, pursuant to an informal or voluntary network fee agreement with a health care provider in accordance with Labor Code §413.011 and §413.0115. Consequently, the Division finds that the insurance carrier is not entitled to pay the health care provider at a contracted fee negotiated by an informal or voluntary network. The services will therefore be reviewed in accordance with applicable Division rules and fee guidelines.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (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 with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- Procedure code 16020 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0015, which, per OPPS Addendum A, has a payment rate of $100.21. This amount multiplied by 60% yields an unadjusted labor-related amount of $60.13. This amount multiplied by the annual wage index for this facility of 0.989 yields an adjusted labor-related amount of $59.47. The non-labor related portion is 40% of the APC rate or $40.08. The sum of the labor and non-labor related amounts is $99.55. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $99.55. This amount multiplied by 200% yields a MAR of $199.10.
- Per Medicare policy, procedure code 96372 may not be reported with procedure code 16020 billed on this same claim. Payment for this service is included in the reimbursement for other services performed. Separate payment is not recommended.
- Procedure code 99283 has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0614, which, per OPPS Addendum A, has a payment rate of $136.70. This amount multiplied by 60% yields an unadjusted labor-related amount of $82.02. This amount multiplied by the annual wage index for this facility of 0.989 yields an adjusted labor-related amount of $81.12. The non-labor related portion is 40% of the APC rate or $54.68. The sum of the labor and non-labor related amounts is $135.80. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $135.80. This amount multiplied by 200% yields a MAR of $271.60.

5. The total allowable reimbursement for the services in dispute is $470.70. This amount less the amount previously paid by the insurance carrier of $368.93 leaves an amount due to the requestor of $101.77. 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 $101.77.

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 $101.77 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	May 23, 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.