



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

COLUMBUS COMMUNITY HOSPITAL  
HOME HEALTH AGENCY

**Respondent Name**

TEXAS MUTUAL INSURANCE COMPANY

**MFDR Tracking Number**

M4-11-1671-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

January 10, 2011

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "1.25"

**Amount in Dispute:** \$613.99

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "A PPO contract exists between Texas Mutual's utilization review agent, Coventry Health Care through Focus/Beech Street, and the requestor. The payment amounts on the various codes billed by the requestor were derived from the terms of the contract."

**Response Submitted by:** Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 10, 2010 to June 30, 2010	Home Health Services, procedure codes G0151 and G0154	\$613.99	\$343.23

#### 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. Texas Administrative Code §134.204 sets out fee guidelines for Workers' Compensation specific services.
2. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - B5 – COVERAGE/PROGRAM GUIDELINES WERE NOT MET OR WERE EXCEEDED.
  - 217 – BASED ON PAYER REASONABLE AND CUSTOMARY FEES. NO MAXIMUM ALLOWABLE DEFINED BY LEGISLATED FEE ARRANGEMENT. (NOTE: TO BE USED FOR WORKERS' COMPENSATION ONLY)
  - 426 – REIMBURSED TO FAIR AND REASONABLE.
  - 775 – NETWORK REDUCTIONS BASED ON FOCUS/BEECH STREET CONTRACT. FOR QUESTIONS REGARDING NETWORK REDUCTIONS CALL 1-800-243-2336

## **Issues**

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

## **Findings**

1. The insurance carrier reduced payment for disputed services with reason code 775 – “NETWORK REDUCTIONS BASED ON FOCUS/BEECH STREET CONTRACT. FOR QUESTIONS REGARDING NETWORK REDUCTIONS CALL 1-800-243-2336” Review of the submitted information found no documentation to support that the disputed services are subject to a contract between the parties to this dispute. Nevertheless, on March 15, 2011, the Division requested the respondent to provide documentation to support the contractual payment reductions in accordance with Labor Code Sec. 413.011(d-3) and (d-1)(2), as well as 28 Texas Administrative Code §133.4.

Labor Code Sec. 413.011(d-1) requires that:

If a carrier or the carrier's authorized agent chooses to use an informal or voluntary network to obtain a contractual fee arrangement, there must be a contractual arrangement between:

- (1) the carrier or authorized agent and the informal or voluntary network that authorizes the network to contract with health care providers on the carrier's behalf; and
- (2) the informal or voluntary network and the health care provider that includes a specific fee schedule and complies with the notice requirements established under Subsection (d-2).

Labor Code Sec. 413.011(d-2) requires that

“An informal or voluntary network, or the carrier or the carrier's authorized agent, as appropriate, shall notify each health care provider of any person that is given access to the network's fee arrangements with that health care provider within the time and according to the manner provided by commissioner rule.”

Labor Code Sec. 413.011(d-3) states, in pertinent part, that:

An insurance carrier shall provide copies of each contract described by Subsection (d-1) to the division on the request of the division. . . . Notwithstanding Subsection (d-1) or Section 1305.153, Insurance Code, the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract: . . .

(3) does not:

- (A) clearly state that the contractual fee arrangement is between the health care provider and the named insurance carrier or the named insurance carrier's authorized agent; or
- (B) comply with the notice requirements under Subsection (d-2).

28 Texas Administrative Code §133.4(c) further requires that:

Required Notice. Each informal network or voluntary network, or the insurance carrier, or the insurance carrier's authorized agent, as appropriate, shall notify each affected health care provider of any person that is given access to the informal or voluntary network's fee arrangement with that health care provider within the time and manner provided by this section.

28 Texas Administrative Code §133.4(g) states that:

The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:

- (1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or
- (2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115.

Review of the submitted information finds no documentation to support a contract between the carrier or authorized agent and the alleged informal or voluntary network that authorizes the network to contract with health care providers on the carrier's (Texas Mutual's) behalf in accordance with Subsection (d-1)(1). No documentation was found to support notice to the health care provider that Texas Mutual had been given access to the network's fee arrangements with the health care provider in accordance with Labor Code 413.011(d), Subsections (d-2), (d-1)(2), and (d-3)(3)(B), or 28 Texas Administrative Code §133.4. Review of the submitted information finds no documentation that clearly states that the contractual fee arrangement is between the health care provider and the named insurance carrier (Texas Mutual) or the named insurance carrier's authorized agent in accordance with Subsection (d-3)(3)(A). The Division therefore finds that the insurance carrier's payment reduction reason is not supported. Consequently, the Division concludes that the insurance carrier is not entitled to pay the health care provider at a contracted fee negotiated by an informal network or voluntary network and may not pay fees that are inconsistent with the Division's fee guidelines.

2. This dispute relates to home health services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(f), which requires that “To determine the MAR amount for home health services provided through a licensed home health agency, the MAR shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies.” Reimbursement is calculated as follows:
- Procedure code G0154, service date May 10, 2010, has a per-visit fee published in the Texas Medicaid fee schedule, effective for the date of service, of \$100.94. This amount multiplied by 125% results in a MAR of \$126.18. The insurance carrier paid \$63.47, leaving an amount due to the requestor of \$62.71. This amount is recommended.
  - The requestor’s *Table of Disputed Services* lists procedure code G0154, date of service May 11, 2010 as in dispute; however, documentation does not support that the service was performed or billed for this service date. Reimbursement cannot be recommended.
  - Procedure code G0154, service date May 12, 2010, has a per-visit fee published in the Texas Medicaid fee schedule, effective for the date of service, of \$100.94. This amount multiplied by 125% results in a MAR of \$126.18. The insurance carrier paid \$63.47, leaving an amount due to the requestor of \$62.71. This amount is recommended.
  - Procedure code G0154, service date June 9, 2010, has a per-visit fee published in the Texas Medicaid fee schedule, effective for the date of service, of \$100.94. This amount multiplied by 125% results in a MAR of \$126.18. The insurance carrier paid \$95.08, leaving an amount due to the requestor of \$31.10. This amount is recommended.
  - Procedure code G0154, service date June 11, 2010, has a per-visit fee published in the Texas Medicaid fee schedule, effective for the date of service, of \$100.94. This amount multiplied by 125% results in a MAR of \$126.18. The insurance carrier paid \$95.08, leaving an amount due to the requestor of \$31.10. This amount is recommended.
  - Procedure code G0154, service date June 21, 2010, has a per-visit fee published in the Texas Medicaid fee schedule, effective for the date of service, of \$100.94. This amount multiplied by 125% results in a MAR of \$126.18. The insurance carrier paid \$95.20, leaving an amount due to the requestor of \$30.98. This amount is recommended.
  - Procedure code G0154, service date June 25, 2010, has a per-visit fee published in the Texas Medicaid fee schedule, effective for the date of service, of \$100.94. This amount multiplied by 125% results in a MAR of \$126.18. The insurance carrier paid \$95.20, leaving an amount due to the requestor of \$30.98. This amount is recommended.
  - Procedure code G0154, service date June 28, 2010, has a per-visit fee published in the Texas Medicaid fee schedule, effective for the date of service, of \$100.94. This amount multiplied by 125% results in a MAR of \$126.18. The insurance carrier paid \$63.47, leaving an amount due to the requestor of \$62.71. This amount is recommended.
  - Procedure code G0154, service date June 30, 2010, has a per-visit fee published in the Texas Medicaid fee schedule, effective for the date of service, of \$100.94. This amount multiplied by 125% results in a MAR of \$126.18. The insurance carrier paid \$95.20, leaving an amount due to the requestor of \$30.98. This amount is recommended.
  - Procedure code G0151, service dates May 17, May 21, and June 7, 2010, does not have a published fee in the Texas Medicaid fee schedule for home health agencies. Reimbursement for these services is therefore determined according to §134.204(d) which states that “When there is no negotiated or contracted amount that complies with §413.011 of the Labor Code, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider’s usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title (relating to Medical Reimbursement).” §134.1(g) states, in pertinent part, that “The insurance carrier shall consistently apply fair and reasonable reimbursement amounts and maintain, in reproducible format, documentation of the insurance carrier’s methodology(ies) establishing fair and reasonable reimbursement amounts.” The insurance carrier allowed payments for these services in the amount of \$63.47, \$70.21, and \$63.47 (respectively), reducing payment from the provider’s billed charges based on reason code 426 – “REIMBURSED TO FAIR AND REASONABLE.” Review of the submitted information finds insufficient documentation to support a different reimbursement amount from the amounts determined by the carrier; therefore, no additional payment is recommended.
3. The total recommended payment for the services in dispute is \$1,206.55. This amount less the amount previously paid by the insurance carrier of \$863.32 leaves an amount due to the requestor of \$343.23. 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 \$343.23.

**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 \$343.23 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

	Grayson Richardson	November 4, 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.**