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
TEXAS HEALTH SOUTHLAKE

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-19-2427-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 4, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/denied APC – CPT 24342 is calculated using the Whole APC…"

Amount in Dispute: $3,830.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary (dated January 28, 2019): "the claimant is in a certified health care network. The name of that network is the Sedgwick Preferred Network. … the proper venue to handle medical fee disputes is through the network itself."

Supplementary Response Summary (dated January 31, 2019): "While it remains the carrier's position that the Medical Review Division is not the correct venue to handle this medical fee dispute involving a medical bill in which the claimant is in a certified health care network, the carrier has reprocessed the provider's medical bill. We are attaching a copy of the carrier's EOR dated January 17, 2019 that recommends additional reimbursement of $2,895.31."

Response Submitted by: Flahive, Odgen & Latson, Attorneys at Law, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 3, 2018	Outpatient Hospital Services	$3,830.61	$0.00

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 hospital facility fee guideline for outpatient services.
3. 28 Texas Administrative Code §133.240 sets out requirements regarding medical bill payments and denials.
4. 28 Texas Administrative Code §133.250 sets out requirements for reconsideration of medical bills.
5. Insurance Code 1305.005 sets out requirements regarding notice to injured employees.
6. Insurance Code Chapter 1305 sets out provisions regarding Workers' Compensation Health Care Networks.
7. The division notes that, after the filing of the request for Medical Fee Dispute Resolution, the respondent submitted, as a supplementary response, documentation to support the insurance carrier reprocessed the disputed bill and issued additional payment of $2895.31, which was mailed to the provider on January 18, 2019.

8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - OA – THE AMOUNT ADJUSTED IS DUE TO BUNDLING OR UNBUNDLING OF SERVICES.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 1014 - The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

<u>Issues</u>

1. Are the disputed services subject to the dispute processes for claims provided through a Workers' Compensation Health Care Network (HCN) established under Insurance Code Chapter 1305?
2. Did the respondent raise new defenses that were not presented to the requestor prior to MFDR?
3. Is the requestor entitled to additional reimbursement?

<u>Findings</u>

1. The respondent asserts that "the claimant is in a certified health care network. The name of that network is the Sedgwick Preferred Network. … the proper venue to handle medical fee disputes is through the network itself."

   Review of information maintained by the division finds the insurance carrier has not reported to the division that this injured employee's claim is subject to a certified Workers' Compensation Health Care Network (HCN) established under Insurance Code Chapter 1305.

   Insurance Code §1305.005(d)(1) requires employers to "obtain a signed acknowledgment from each employee . . . that the employee has received information concerning the network and the network's requirements."

   Insurance Code §1305.005(h) requires "An insurance carrier that establishes or contracts with a network is liable for the payment of medical care under the requirements of Title 5, Labor Code, for an injured employee who does not receive notice until the employee receives notice of network requirements under this section."

   Review of submitted information finds no acknowledgment of signed notice or other documentation to support the injured employee's claim is subject to the requirements of a workers' compensation HCN under Chapter 1305.

   Consequently, the carrier is liable for payment of medical care under the requirements of Title 5, Labor Code.

   Moreover, Rule §133.240(f)(15) requires that the paper form of an explanation of benefits (EOB) shall include the "workers' compensation health care network name (if applicable);" review of the submitted EOBs finds no mention of the alleged network or that the claim is subject to the provisions of an HCN.

   The fields on the EOB indicating the network and subnetwork names are blank. No notice of any name of a workers' compensation HCN established in accordance with Insurance Code Chapter 1305 was found elsewhere on the EOB. No notice was given on the EOB of the provider's rights and responsibilities under network rules, including informing the provider of their right to and process for seeking dispute resolution from the network. In contrast, the EOB advises the provider to file an appeal with the insurance carrier "pursuant to [division Rule] §133.250," if the provider disagrees with the carrier's determination. For these reasons, the division concludes the carrier's EOBs fail to meet the requirements of Rule §133.240(f)(15).

   Documentation was provided to support preauthorization of the services; however, the approval was issued in the name of "Sedgwick Claims Management Services, Inc." — without any mention of "Sedgwick Preferred Network" nor any notice on the authorization approval that the claim was subject to a workers' compensation HCN.

   Based on the submitted documentation, the division finds no evidence to support that the injured employee's claim is subject to the requirements of a workers' compensation HCN established under Insurance Code Chapter 1305.

2. 28 Texas Administrative Code §133.307(d)(2)(F) requires that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   As found above, the respondent failed to support the injured employee's claim is subject to an HCN. Even if the claim *were* subject to the provisions of an HCN, the respondent provided no information to support giving notice to the health care provider of this defense on the EOBs or at any time prior to the request for medical fee dispute resolution. This constitutes grounds for the division to find a waiver of such defenses at MFDR and the division finds a waiver here. Any such newly raised defenses will not be considered in this review.

3. This dispute regards outpatient facility services subject to DWC's *Hospital Facility Fee Guideline*, Rule §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors published in the Federal Register, as modified by DWC rules. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for the disputed facility services unless separate payment of implantables is requested. Separate reimbursement for implants was not requested.

   Medicare assigns an Ambulatory Payment Classification (APC) to OPPS services based on billed procedure codes and supporting documentation. The APC determines the payment rate. Reimbursement for ancillary items and services is packaged with the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 24342 has status indicator J1, for procedures paid at a comprehensive rate. This service is assigned APC 5114. The OPPS Addendum A rate is $5,606.42, which is multiplied by 60% for an unadjusted labor amount of $3,363.85. This is in turn multiplied by the facility wage index of 0.9636 for an adjusted labor amount of $3,241.41. The non-labor portion is 40% of the APC rate, or $2,242.57. The sum of the labor and non-labor portions is $5,483.98. Per *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 4, §10.7.1, if the cost of a service exceeds both 1.75 times the OPPS payment and also the fixed-dollar threshold of $4,150, the outlier payment is 50% of the amount in excess of 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.391. This ratio is multiplied by the billed charge of $8,124.25 for a cost of $3,176.58. Additionally, the cost of other packaged line items is added to the paid line item. The sum of packaged costs is $3,703.74, which is added to the service cost for a total cost of $6,880.32. The cost of services exceeds the fixed-dollar threshold of $4,150; however, the amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. These services do not qualify for outlier payment. The Medicare facility specific amount of $5,483.98 is multiplied by 200% for a MAR of $10,967.96.
   - Payment for all other services on the bill is packaged with the primary comprehensive J1 service (except those with status F, G, H, L or U; certain inpatient and preventive services; ambulance and mammography) according to Medicare policy regarding comprehensive APCs. Reimbursement for all items is included in the payment for the primary procedure. Please see *Medicare Claims Processing Manual* Chapter 4 §10.2.3 for further details.

   The total recommended reimbursement for the disputed services is $10,967.96. The insurance carrier paid $8,072.65 during the bill review process. After the health care provider requested Medical Fee Dispute Resolution, the carrier issued additional payment of $2,895.31, for a total combined payment of $10,967.96. The amount remaining due to the requestor is now $0.00. Additional payment is not recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

After the provider requested Medical Fee Dispute Resolution, the insurance carrier issued additional payment for the disputed services in the amount of the remaining balance as determined in accordance with division fee guidelines. For the reasons stated above, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

______________________________	Grayson Richardson	February 1, 2019
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.

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 form's instructions. The division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 28 Texas Administrative Code §141.1(d).

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