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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
ETMC HENDERSON

**Respondent Name**
NEW HAMPSHIRE INSURANCE COMPANY

**MFDR Tracking Number**
M4-19-3992-02

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
April 29, 2019

**Response Submitted By**
CorVel

## *REQUESTOR'S POSITION SUMMARY*

"The initial bill was denied as the patient not being found in their system. The appeal was denied as a duplicate."

## *RESPONDENT'S POSITION SUMMARY*

"ETMC Henderson is not entitled to reimbursement ... based on failure to submit a complete medical bill to the appropriate workers' compensation insurance carrier. ... On 09/01/17, the correctional facility where the employee is, employed was, taken over the state of Texas. ... correctional facilities covered by the state of Texas are, administered by the State Office of Risk Management (SORM)."

## *SUMMARY OF DISPUTE*

| Dates of Service | Disputed Services | Dispute Amount | Amount Due |
|---|---|---|---|
| May 12, 2018 | Outpatient Hospital Services | $1,158.23 | $1,158.23 |

## AMENDED FINDINGS AND DECISION

By Official Order Number 2807 dated October 17, 2013, the undersigned has been delegated authority by the Commissioner to **amend** fee dispute decisions.

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

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 hospital facility fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – DUPLICATE CLAIM/SERVICE
   - R1 – DUPLICATE BILLING

Issues

1. Did New Hampshire Insurance Company present its liability denial reason to ETMC before the filing of this dispute?
2. Is reimbursement due?

Findings

1. New Hampshire Insurance Company asserts that "On 09/01/17, the correctional facility where the employee is, employed was, taken over by the state of Texas. ... correctional facilities covered by the state of Texas are, administered by the State Office of Risk Management (SORM)."

   The medical fee dispute Rule §133.307 (d)(2)(F) states that the carrier's 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 of the dispute.

   No evidence was found to support that New Hampshire Insurance Company presented its liability defense before the filing of this medical fee dispute.

   Specifically, the division reviewed the explanation of benefits provided and found that New Hampshire Insurance Company:

   1) Failed to Issue an explanation of benefits with an adjustment code that included an appropriate denial code and reason - Rule §133.240 (f)(17)(G)&(H); and
   2) Failed to prove that it filed the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title as a result of its **belief that New Hampshire Insurance Company is not liable for the injury due to lack of insurance coverage** - Rule §133.240 (h)(2).

   New Hampshire Insurance Co failed to present the defenses raised in its response in a manner that conforms with the requirements of 28 TAC §133.240. Absent any evidence that New Hampshire Insurance Co or an agent acting on New Hampshire Insurance Co's behalf timely presented any defenses to the provider that conform with the requirements of Title 28, Part 2, Chapter 133, Subchapter C, the Division finds that the services are eligible for reimbursement.

2. This dispute regards outpatient facility services subject to DWC's *Hospital Facility Fee Guideline*, Rule §134.403, which requires the maximum allowable reimbursement (MAR) be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors modified by DWC rules.

   Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for these disputed hospital facility services.

   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 codes 73130, 12001, and 90471 have status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for status T code 10160 and status V APC 5024 paid for the same service date.
   - Procedure code 10160 has status indicator T, for procedures subject to multiple-procedure reduction. The highest paying status T unit is paid at 100%; all others at 50%. This code is paid at 100%. This code is assigned APC 5052. The OPPS Addendum A rate is $310.80, multiplied by 60% for an unadjusted labor amount of $186.48, in turn multiplied by the facility wage index of 0.7889 for an adjusted labor amount of $147.11. The non-labor portion is 40% of the APC rate, or $124.32. The sum of the labor and non-labor portions is the Medicare facility specific amount of $271.43. This is multiplied by 200% for a MAR of $542.86.

- Procedure code 99284 is an outpatient visit assigned APC 5024 with status V. The OPPS Addendum A rate is $355.53, multiplied by 60% for an unadjusted labor amount of $213.32, in turn multiplied by the facility wage index of 0.7889 for an adjusted labor amount of $168.29. The non-labor portion is 40% of the APC rate, or $142.21. The sum of the labor and non-labor portions is the Medicare facility specific amount of $310.50. This is multiplied by 200% for a MAR of $621.00.

The total recommended reimbursement for the disputed services is $1,163.86. The insurance carrier paid $0.00. The requestor is seeking additional reimbursement of $1,158.23. This amount is recommended.

Conclusion

The division finds that payment is due. The amount ordered is $1,158.23.

## *ORDER*

The requestor is entitled to additional reimbursement. The division hereby ORDERS the respondent to remit to the requestor $1,158.23, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

| Signature | Greg Arendt<br>Medical Fee Dispute Resolution Team Leader | June 13 , 2019<br>Date |
|---|---|---|

## *RIGHT TO APPEAL*

Either party to this medical fee dispute may seek review of this division decision. To appeal, submit form division Form-045M titled ***Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)*** found at https://www.tdi.texas.gov/forms/form20numeric.html.

Follow the instructions on pages 3 and 4. The request must be received by the division within twenty days of your receipt of this decision. This decision becomes final if the request for review of this decision is not submitted within twenty days.

The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

If you have questions about the division Form-045M, please call CompConnection at 1-800-252-7031, Option 3 or you may email your question to CompConnection@tdi.texas.gov

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, Option 1.