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 SPINE AND JOINT HOSPITAL

MFDR Tracking Number
M4-19-4136-01

MFDR Date Received
May 14, 2019

Respondent Name
GRAPHIC ARTS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative
Box Number 01

Response Submitted By
Brown Sims

REQUESTOR'S POSITION SUMMARY

"Ever since the first denial, I have attempted to obtain further information about the network requirements… after speaking with multiple Genex representatives, they were unable to provide any network information."

RESPONDENT'S POSITION SUMMARY

"It is Respondent's position that it appropriately denied payment of Requestor's invoice dated May 29, 2018 as treatment was rendered by an out-of-network provider."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 29, 2018	Outpatient Hospital Services	$12,719.55	$1,630.36

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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 §133.240 sets out requirements for payment and denial of medical bills.
3. 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
4. Insurance Code Chapter 1305 sets out requirements for certified workers' compensation health care networks.
5. Insurance Code §1305.051 requires certification of workers' compensation health care networks.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 242 – SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS.

Issues

1. Are the disputed services subject to the provisions of a workers' compensation certified health care network?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 242 – “Services not provided by network/primary care providers.”

   Insurance Code §1305.051 requires certification of workers’ compensation health care networks. Based on information maintained by the division, neither Utica National Insurance Group nor Genex Services, Inc. are certified by the division as a workers' compensation health care network (HCN) in accordance with Insurance Code Chapter 1305. No information was presented to MFDR to support that the employee’s claim is subject to a certified HCN established in accordance with Chapter 1305.

   Furthermore, Rule §133.240(f)(15) requires the paper form of a carrier’s explanation of benefits (EOB) to include the “workers’ compensation health care network name (if applicable)” when the carrier pays or denies a bill. The carrier’s EOB does not make any reference to the alleged network name or include the name of any workers' compensation HCN certified in accordance with Insurance Code §1305.051. The insurance carrier failed to meet the requirements of Rule §133.240(f)(15) and thus failed to give proper notice to the health care provider.

   Lastly, review of records held by the division finds no information to support the insurance carrier has enrolled the injured employee in a certified HCN in accordance with the requirements of Insurance Code Chapter 1305. The response does not include any documentation to support the injured employee is enrolled in a certified HCN.

   The division concludes the insurance carrier’s denial reasons are not supported. Consequently, the disputed services will be reviewed for payment in accordance with division rules and fee guidelines.

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 is calculated as follows:

   - Procedure code 81025 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
   - Procedure codes 25246, Q9966, and A9579 have status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
   - Procedure code 73115 is assigned APC 5571. The OPPS Addendum A rate is $252.74. This is multiplied by 60% for an unadjusted labor amount of $151.64, which is in turn multiplied by the facility wage index of 0.787 for an adjusted labor amount of $119.34. The non-labor portion is 40% of the APC rate, or $101.10. The sum of the labor and non-labor portions is the Medicare facility specific amount of $220.44. This is multiplied by 200% for a MAR of $440.88.
   - Procedure code 73222 is assigned APC 5573, with an OPPS Addendum A rate of $681.88. This is multiplied by 60% for an unadjusted labor amount of $409.13, which is in turn multiplied by the facility wage index of 0.787 for an adjusted labor amount of $321.99. The non-labor portion is 40% of the APC rate, or $272.75. The sum of the labor and non-labor portions is the Medicare facility specific amount of $594.74. This is multiplied by 200% for a MAR of $1,189.48.

   The total recommended reimbursement for the disputed services is $1,630.36. The insurance carrier paid $0.00. The amount due is $1,630.36. This amount is 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 findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds the requestor has established that additional payment is due. As a result, the amount ordered is $1,630.36.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, the division finds the requestor is entitled to additional reimbursement. The division hereby ORDERS the respondent to remit to the requestor $1,630.36, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

______________________	Grayson Richardson	May 31, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). 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 field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute 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.