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
DOCTORS HOSPITAL AT RENAISSANCE

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-4166-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 17, 2019

Response Submitted By
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"We rendered services on good faith based on the information that was exchanged and therefore are also requesting that our claim be reprocessed for payment."

RESPONDENT'S POSITION SUMMARY

"Texas Mutual has no evidence the requestor, a non-network provider, received out of network approval to provide the service or treatment."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 7, 2019	Hospital Outpatient Clinic Visit: G0463	$207.02	$207.02

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 §134.403 sets out the hospital facility fee guideline for outpatient services.
3. Insurance Code Chapter 1305 sets out requirements regarding workers' compensation health care networks.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 243 – SERVICES NOT AUTHORIZED BY NETWORK/PRIMARY CARE PROVIDERS.
   - D27 – PROVIDER NOT APPROVED TO TREAT WORKWELL, TX NETWORK CLAIMANT. FOR NET WORK INFORMATION CALL 844-867-2338
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (800) 859-5995 X3994.
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 243 – SERVICES NOT AUTHORIZED BY NETWORK/PRIMARY CARE PROVIDERS.
   - D27 – PROVIDER NOT APPROVED TO TREAT WORKWELL, TX NETWORK CLAIMANT. FOR NET WORK INFORMATION CALL 844-867-2338

   The requestor's position statement asserts the injured employee's claim "is in the WorkWell Network. Texas Mutual reviewed its online Network provider directory for the requestor's name and of its tax identification number and found no evidence DOCTORS HOSPITAL AT RENAISSANCE is a participant in that Network."

   Based on information maintained by the division, the insurance carrier has not previously notified the division that the injured employee has been enrolled in a certified workers' compensation health care network (HCN) established in accordance with Insurance Code Chapter 1305. The response did not include any documentation to support the injured employee's claim is subject to a certified HCN.

   The division concludes the insurance carrier failed to support the above denial reasons. Consequently, the disputed services will be reviewed for reimbursement 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 the disputed hospital facility services.

   Reimbursement for the disputed services is calculated as follows:

   - HCPCS code G0463 has status indicator J2, outpatient visit, assigned APC 5012. The OPPS Addendum A rate is $115.85. This is multiplied by 60% for an unadjusted labor amount of $69.51, which is in turn multiplied by the facility wage index of 0.8224 for an adjusted labor amount of $57.17. The non-labor portion is 40% of the APC rate, or $46.34. The sum of the labor and non-labor portions is the Medicare facility specific amount of $103.51. This is multiplied by 200% for a MAR of $207.02.

   The total recommended reimbursement for the disputed services is $207.02. The insurance carrier paid $0.00. The amount due is $207.02. 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 above, the division finds that additional payment is due. As a result, the amount ordered is $207.02.

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 $207.02, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	June 14, 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.