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 HEB

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-19-4911-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 19, 2019

Response Submitted By
Flahive, Odgen & Latson, Attorneys at Law, PC

REQUESTOR'S POSITION SUMMARY

"These charges were incorrectly denied… the correct parent code for CPT codes 96366 & 96375 are both 96365 which was billed on date of service 11/10/18… Per CMS 'only the initial drug administration service is to be reported per vascular access site per encounter…'"

RESPONDENT'S POSITION SUMMARY

"First, this is a denied claim. We are attaching a PLN-1… Secondly, the claimant is in the Sedgwick preferred HCN… The correct venue to resolve a medical fee dispute involving a network claim is through the network itself."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 10, 2018 to November 12, 2018	Hospital Services	$1,152.49	$0.00

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. 28 Texas Administrative Code §133.240 sets out requirements regarding medical bill payments and denials.
4. Texas Insurance Code Chapter 1305 sets out requirements for workers' compensation health care networks.
5. 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.
   - 906 – IN ACCORDANCE WITH CLINICAL BASED CODING EDITS (NATIONAL CORRECT CODING INITIATIVE/OUTPATIENT CODE EDITOR), COMPONENT CODE OF COMPREHENSIVE MEDICINE, EVALUATION AND MANAGEMENT SERVICES PROCEDURE (90000-99999) HAS BEEN DISALLOWED.
   - 107 – CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT PREVIOUSLY PAID OR IDENTIFIED ON THIS CLAIM.
   - 292 – THIS PROCEDURE CODE IS ONLY REIMBURSED WHEN BILLED WITH THE APPROPRIATE INITIAL BASE CODE.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
   - 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.

- 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.
- 536 – THESE CHARGES HAVE ALREADY BEEN BILLED AND PAID FOR ACCORDING TO FEE SCHEDULE AND/OR REASONABLE GUIDELINES. NO FURTHER PAYMENT IS DUE.

Issues

1. Are there any unresolved issues of liability for the disputed services?
2. Is the injured employee's claim subject to a certified workers' compensation health care network?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent asserts this dispute is not eligible for review as there are unresolved issues of liability for the injury. The carrier presented documentation of a PLN-1 plain language notice denying liability for the claim that was sent to the injured employee dated November 21, 2018. No copy of that notice was sent to the health care provider.

   No information was found to support the insurance carrier notified the health care provider of any denial reasons or defenses related to liability or compensability before the filing of the request for medical fee dispute resolution.

   Rule §133.240(f)(17)(G) and (H) set out the requirements for the carrier to give notice to the health care provider of the adjustment reason code(s) and explanation of the reasons for reduction or denial for each billed health care service. Rule §133.240(h) further specifies additional notice requirements if the carrier denies payment based on reasons related to liability or compensability.

   None of the submitted explanations of benefits contain any adjustment reason codes or explanations for denial related to liability for the employee's claim or compensability of the injury.

   Rule §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."

   The insurance carrier's response raises new defenses that were not presented to the health care provider before the filing of the request for medical fee dispute resolution. The insurance carrier's failure to give notice to the health care provider of specific codes or explanations for payment reduction or denial, as required by Rule §133.240, constitutes grounds for the division to find a waiver of those defenses during Medical Fee Dispute Resolution — and the division finds such a waiver here.

   Consequently, the division concludes the insurance carrier has waived the right to raise such new defenses during MFDR due to failure to meet the notice requirements in the Labor Code and division rules. This dispute is therefore eligible for MFDR. Any such new defenses or denial reasons will not be considered in this review.

2. The respondent asserts the health care provider is not entitled to Medical Fee Dispute Resolution because "the claimant is in the Sedgwick preferred HCN." Review of records maintained by the division finds no previous notification to the division that the injured employee is enrolled in a certified workers' compensation health care network (HCN) established in accordance with Insurance Code Chapter 1305.

   The response did not include documentation to support the injured employee was enrolled in a certified HCN on the disputed service dates. The respondent did not present any documentation to support the insurance carrier had access to the alleged network on the service dates. No documentation was found to support the health care provider participated with the network on those service dates. Nor did the respondent present any evidence of a contract between the carrier and the provider or between the provider and a workers' compensation HCN to which the carrier had access on the service dates.

   The respondent failed to support its assertion that the disputed services are subject to a certified workers' compensation HCN under the provisions of Texas Insurance Code Chapter 1305. These services will therefore be reviewed for reimbursement in accordance with the provisions of the Texas Labor Code and division rules.

3. This MFDR request regards payment for disputed hospital facility services.

   Rule §133.307(c) requires that requests for MFDR shall be filed in the form and manner prescribed by the division.

   Rule §133.307(c)(2)(J) requires the request to include a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier and for an appeal.

   Review of the submitted request and response finds no copy of a medical bill for the disputed services.

   Rule §133.307(f)(1) provides that:

   > The division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the division no later than 14 days after receipt of this request. If the division does not receive the requested additional information within 14 days after receipt of the request, then the division may base its decision on the information available. The party providing the additional information shall forward a copy of the additional information to all other parties at the time it is submitted to the division.

   The division notified the requestor of the missing documentation July 26, 2019. To date, no copy of the bill has been received. Accordingly, this decision is based on the information available at the time of review.

   The division finds the requestor failed to meet the documentation requirements of Rule §133.307(c)(2)(J) necessary to support the request for additional payment. The submitted documentation contains insufficient information for the division to calculate the appropriate fees or to adjudicate the payment for the disputed services. Consequently, no additional payment can be 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 the requestor has not established that additional payment is due. As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	August 16, 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.