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
BAPTIST ST. ANTHONY'S HEALTH

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-20-0220-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 23, 2019

Response Submitted By
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position statement for consideration in this review.

RESPONDENT'S POSITION SUMMARY

"Texas Mutual claim… and BAPTIST ST ANTHONYS HEALTH SYSTEM are participants in the WorkWell Network. (Attachment)… Because this is network healthcare Rule 133.307 does not apply."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
June 30, 2019	Outpatient Hospital Services	$142.88	$142.88

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 (DWC) in Title 28, Part 2 of the Texas Administrative Code.

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 §134.807 sets out state specific requirements for carrier medical bill reporting.
4. 28 Texas Administrative Code Chapter 134, Subchapter I, sets out insurance carrier reporting requirements.
5. Texas Labor Code §402.082 requires DWC to maintain information on every compensable injury.
6. Texas Insurance Code Chapter 1305 sets out requirements for workers' compensation health care networks.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 370 – THE HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 616 – THIS CODE HAS STATUS Q APC INDICATOR AND IS PACKAGED INTO OTHER APC CODES THAT HAVE BEEN IDENTIFIED BY CMS.
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 729 - THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR COVENTRY CONTRACT. FOR QUESTIONS PLEASE CALL 1-800-937-6824
   - 767 – PAID PER O/P FG AT 200%: IMPLANTS NOT APPLICABLE OR SEPARATE REIMBURSEMENT (WITH CERT) NOT REQUESTED PER RULE 134.403(G)

- A16 - THE REIMBURSEMENT FOR HEALTH CARE SERVICES ARE SUBJECT TO WORKWELL, TX CONTRACTS, A CERTIFIED WC HCN (INS CODE CH. 1305)
- 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. Did the health care provider submit a position statement with their MFDR request?
2. Is the dispute subject to a certified workers' compensation health care network under Insurance Code Chapter 1305?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The health care provider did not submit a position statement for review with the request for dispute resolution.

   28 Texas Administrative Code §133.307(c)(2) specifies the information and records the requestor shall provide with the MFDR request, including 28 TAC §133.307(c)(2)(N), "a position statement of the disputed issue(s)," explaining:

   (i) the requestor's reasoning for why the disputed fees should be paid or refunded,
   (ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and
   (iii) how the submitted documentation supports the requestor's position for each disputed fee issue

   Requestors are required to provide the information and records specified in Rule §133.307(c)(2) in the form and manner prescribed by the division. This decision is based on the information available at the time of review.

2. The insurance carrier denied disputed services with claim adjustment reason codes:
   - A16 - THE REIMBURSEMENT FOR HEALTH CARE SERVICES ARE SUBJECT TO WORKWELL, TX CONTRACTS, A CERTIFIED WC HCN (INS CODE CH. 1305)
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
   - 729 - THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR COVENTRY CONTRACT. FOR QUESTIONS PLEASE CALL 1-800-937-6824

   The respondent asserts, "Texas Mutual claim… and BAPTIST ST ANTHONYS HEALTH SYSTEM are participants in the WorkWell Network. (Attachment)… Because this is network healthcare Rule 133.307 does not apply."

   Health care arranged by a certified workers' compensation health care network (HCN) established under Insurance Code Chapter 1305 is subject to the dispute processes outlined in Insurance Code Chapter 1305; however, the respondent did not support that the disputed health care was arranged by a certified workers' compensation HCN.

   Labor Code §402.082(a)(3) requires DWC to maintain information on every compensable injury as to the "identification of whether the claimant is receiving medical care through a workers' compensation health care network certified under Chapter 1305, Insurance Code." Based on information maintained by the division, the injured employee was not enrolled in the alleged network on the date of service.

   28 Texas Administrative Code Chapter 134, Subchapter I, sets out reporting requirements for all insurance carriers for each medical bill; including Rule 28 TAC §134.807(f)(7), which requires carriers to report whether services were performed within a certified workers' compensation HCN or under a contractual fee arrangement — for each medical bill on a workers' compensation claim. The insurance carrier has not previously reported to the division that these services were performed within a certified HCN or under a contractual fee arrangement.

   The respondent did not support the injured employee was enrolled in the alleged network on the date of service. The respondent's printout did show provider participation in a network; however, the network named in the printout is different from the network name asserted in both the position statement and explanations of benefits. No evidence was presented of a contract between the provider and the alleged network or carrier. Lastly, the carrier did not report the services are subject to a certified HCN or contract as required by DWC reporting rules in 28 TAC 134, Subchapter I. The division thus concludes Insurance Code Chapter 1305 is not applicable to this dispute. Accordingly, MFDR will review the disputed services for payment consistent with division rules and fee guidelines.

3. This dispute regards outpatient facility services subject to DWC's *Hospital Facility Fee Guideline*, 28 TAC §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 28 TAC §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for these 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 82962 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
   - Procedure codes 73060 and 73590 have status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for other services performed the same day.
   - Procedure codes 70450, and 72125 have status indicator Q3, for packaged codes paid through a composite APC. Codes assigned to composites are major components of a single episode of care; the hospital receives one payment for any combination of designated procedures. These services are assigned composite APC 8005, for computed tomography (CT) services without contrast. The OPPS Addendum A rate is $264.95, which is multiplied by 60% for an unadjusted labor amount of $158.97, and in turn multiplied by the facility wage index of 0.8154 for an adjusted labor amount of $129.62. The non-labor portion is 40% of the APC rate, or $105.98. The sum of the labor and non-labor portions is the Medicare facility specific amount of $235.60; this is multiplied by 200% for a MAR of $471.20.
   - Procedure code 29799 represents a hospital procedure assigned APC 5101. The OPPS Addendum A rate is $134.62, which is multiplied by 60% for an unadjusted labor amount of $80.77, and in turn multiplied by the facility wage index of 0.8154 for an adjusted labor amount of $65.86. The non-labor portion is 40% of the APC rate, or $53.85. The sum of the labor and non-labor portions is the Medicare facility specific amount of $119.71; this is multiplied by 200% for a MAR of $239.42.
   - Procedure code 99285 represents an emergency room visit assigned APC 5025. The OPPS Addendum A rate is $525.30, which is multiplied by 60% for an unadjusted labor amount of $315.18, and in turn multiplied by the facility wage index of 0.8154 for an adjusted labor amount of $257.00. The non-labor portion is 40% of the APC rate, or $210.12. The sum of the labor and non-labor portions is the Medicare facility specific amount of $467.12; this is multiplied by 200% for a MAR of $934.24.

   The total recommended reimbursement for the disputed services is $1,644.86. The insurance carrier paid $1,495.14. The requestor is seeking additional reimbursement of $142.88. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of the division is to adjudicate payment following Texas laws and DWC 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 requestor has established payment is due. As a result, the amount ordered is $142.88.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $142.88 plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	October 25, 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 28 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

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