TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Texas Health Rockwall

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-24-0049-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 24, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 2, 2023	0636	$710.43	$690.32
March 2, 2023	0771	$131.12	131.12
March 2, 2023	0999	$0.00	$0.00
	Total	$841.55	$821.44

Requestor's Position

"The claim referenced below was billed with CPT Code 90675 and 90471, and the Medicare reimbursement is $841.55 as referenced in the copy of the Medicare Pricer included in this request. We are in receipt of a payment of $0.00, however, this claim was underpaid by $841.55. Our calculations are based on the Medicare outpatient rates for CPT code 90675 and 90471, which is $841.55."

Amount in Dispute: $841.55

Respondent's Position

"This letter acknowledges receipt of your Network (HCN) complaint on September 11, 2023."

Response submitted by Liberty Mutual

Supplement response received September 25, 2023.

"The provider is not entitled to any reimbursement on the basis that the provider is neither in the Coventry Health Care Network nor did the provider seek approval of the network prior to providing the treatment, forming the basis of the request for Medical Fee Dispute Resolution. …The carrier's EOBs have set out a number of reasons why the provider is not entitled to any reimbursement. This remains the carrier's position.

Response submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.403 sets out the fee guidelines for outpatient hospital services.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 5916 – Provider is not within the Coventry Health Care Network (HCN) for this customer. TX Insurance Code 1305.004.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- U301 – This item has been reviewed on a previously submitted bill, or is currently in process. Notification of Decision has been previously provided or will be issued upon completion of our review.
- 847 – In accordance with OPPS guidelines, the billed revenue codes requires HCPCS/CPT coding. No separate payment is recommended for a non-package revenue code.
- 5751 – Services with a zero line charge can not be reviewed for reimbursement. Resubmit with a billed charge greater than zero.
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment

Issues

1. Did the respondent support claimant within certified network?

2. What rule is applicable to reimbursement?

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking payment of outpatient hospital services rendered in March of 2023. The insurance carrier denied the claim stating the provider was not within the Coventry Network. Review of the information made known to the Division did not support the injured worker is in a certified network. The insurance carrier's denial based on non-network provider is not supported. The disputed charges will be reviewed per applicable fee guidelines.

   DWC Rule 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

   DWC Rule 28 TAC 134.403 (e) states in pertinent part, regardless of billed amount, when no specific fee schedule or contract reimbursement shall be the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

   DWC Rule 28 TAC 134.403 (f) states in pertinent part the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*.

   The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non-labor portion determines the Medicare specific amount. Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

   - Procedure code 90675 has status indicator K, for nonpass-through drugs and biologicals separately paid by APC. This code is assigned APC 9139. The OPPS Addendum A rate is $355.22 multiplied by 60% for an unadjusted labor amount of $213.13, in turn multiplied by facility wage index 0.9528 for an adjusted labor amount of $203.07.

     The non-labor portion is 40% of the APC rate, or $142.09.

The sum of the labor and non-labor portions is $345.16

The Medicare facility specific amount is $345.16 multiplied by 200% for a MAR of $690.32.

- Procedure code 90471 has status indicator Q1. This code is assigned APC 5692. The OPPS Addendum A rate is $67.47 is multiplied by 60% for an unadjusted labor amount of $40.48, in turn multiplied by facility wage index 0.9528 for an adjusted labor amount of $38.57.

  The non-labor portion is 40% of the APC rate, or $26.99.

  The sum of the labor and non-labor portions is $65.56.

  The Medicare facility specific amount is $65.56 multiplied by 200% for a MAR of $131.12.

2. The total recommended reimbursement for the disputed services is $821.44. The insurance carrier paid $0.00. The amount due is $821.44. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that New Hampshire Insurance Co must remit to Texas Health Rockwall $821.44 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 8, 2023 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC

must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.