Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HOUSTON HOSPITAL FOR SPECIALIZED SURGERY

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-1106-01

Carrier's Austin Representative
BOX NUMBER: 54

MFDR Date Received
DECEMBER 17, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As this claim was filed initially on 05/02/13 and was filed with Texas Mutual prior to 95 days after we were notified of the correct workers' compensation insurance carrier, we ask that this claim be reconsidered and allow proper reimbursement. I have included Surgery Scheduling form, Admission Orders and Operative Report for your review."

Amount in Dispute: $16,743.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "HEALTHSOUTH HOPSITAL FOR SPEC SRGY provided no evidence it submitted the bill to Forge USA within 95 days from the date of service. HEALTHSOUTH HOPSITAL FOR SPEC SRGY has not shown that Forge USA issues a policy of group accident and health insurance under which the injured employee is a covered insured; has not shown Forge USA is a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; and has not shown Forge USA is a workers' compensation insurance carrier other than the insurance carrier liable for payment of benefits. HEALTHSOUTH HOPSITAL FOR SPEC SRGY is required to submit a copy of the original medical bill submitted to Forge USA, which it has not done."

Response Submitted By: TEXAS MUTUAL INSURANCE CO

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
April 24, 2013	Outpatient Services	$16,743.13	$4,219.48

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.

4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. 28 Texas Administrative Code §134.403 sets out the fee guideline for outpatient hospital facilities.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired.
   - 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of services.

Issues

1. Is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied..." Review of the documentation submitted by the requestor finds that the requestor has documentation that first billing was incorrectly submitted to the incorrect carrier and proof that the submission to the correct carrier was made within the time frame allowed. Therefore, convincing documentation was found to support that the bill was submitted timely.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds documentation, in the form of a fax confirmation sheet, to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has not forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.
3. In accordance with 28 Texas Administrative Code §134.403(d), (e) and (f) reimbursement is as follows:

   - Procedure code 11012 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0019, which, per OPPS Addendum A, has a payment rate of $336.38. This amount multiplied by 60% yields an unadjusted labor-related amount of $201.83. This amount multiplied by the annual wage index for this facility of 0.992 yields an adjusted labor-related amount of $200.22. The non-labor related portion is 40% of the APC rate or $134.55. The sum of the labor and non-labor related amounts is $334.77. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $167.39 divided by the sum of all S and T APC payments of $2,109.74 gives an APC payment ratio for this line of 0.079342, multiplied by the sum of all S and T line charges of $9,072.00, yields a new charge amount of $719.79 for the purpose of outlier

calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $167.39. This amount multiplied by 200% yields a MAR of $334.78.

- Procedure code 11760 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0133, which, per OPPS Addendum A, has a payment rate of $85.75. This amount multiplied by 60% yields an unadjusted labor-related amount of $51.45. This amount multiplied by the annual wage index for this facility of 0.992 yields an adjusted labor-related amount of $51.04. The non-labor related portion is 40% of the APC rate or $34.30. The sum of the labor and non-labor related amounts is $85.34. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $42.67 divided by the sum of all S and T APC payments of $2,109.74 gives an APC payment ratio for this line of 0.020225, multiplied by the sum of all S and T line charges of $9,072.00, yields a new charge amount of $183.48 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $42.67. This amount multiplied by 200% yields a MAR of $85.34.
- Procedure code 26765 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0062, which, per OPPS Addendum A, has a payment rate of $1,908.84. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,145.30. This amount multiplied by the annual wage index for this facility of 0.992 yields an adjusted labor-related amount of $1,136.14. The non-labor related portion is 40% of the APC rate or $763.54. The sum of the labor and non-labor related amounts is $1,899.68. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $1,899.68. This amount multiplied by 200% yields a MAR of $3,799.36.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,219.48.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,219.48 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 12, 2015 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 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 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.