Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

P MATTHEW O'NEIL
6514 MCNEIL DR BLDG 2 STE 201
AUSTIN TX 78729

Respondent Name
Texas Mutual Insurance

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-14-1684-01

MFDR Date Received
February 7, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The group health plan, Tricare, was billed and once it was denied, the comp carrier was billed timely."

Amount in Dispute: $7,152.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The rational given by the requestor for the late bill is no consistent with the Rule above. No copy of the original bill to Tricare was submitted. Hence, the bill is still untimely."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 15 – 18, 2013	Outpatient Hospital Services	$7,152.12	$7,152.12

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 resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care providers.
5. 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 OF SERVICE FOR SERVICES ON OR AFTER 9/1/05
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED.

Issues

1. Did the requestor forfeit their right to payment?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

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." Unless documentation is found to support that an exception described in Texas Labor Code §408.0272 applies to the services in this dispute. Review of the submitted documentation finds the following:
    a. Claim submitted to PGBA South Region C – February 27, 2013
    b. Rejection from Champus – April 15 ,2013
    c. Copy of letter sent to injured worked requesting primary payer information – April 19, 2013
    d. Champus denial – May 16, 2013 (MA04) "Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
    e. Claim submitted to Workman's comp dated – July 29, 2013
    f. Denial from Texas Mutual denying for timely filing – September 10, 2013
    g. Denial from Texas Mutual affirming denial for timely filing – October 16, 2013
    h. Denial from Texas Mutual affirming denial for timely filing – December 23, 2013
    i. Reconsideration request stating, "…The provider was not notified until 5/3/2013 per a conversation with the patient that the claim was work related. – January 15, 2014

    Per Texas Administrative Code §133.20(b), "(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 information detailed above finds an exception is supported. Therefore, the services in disputed will be reviewed per applicable rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (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 with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
    - Procedure code 85027 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the

applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $8.89. 125% of this amount is $11.11

- Procedure code 73610 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $45.95. This amount multiplied by 60% yields an unadjusted labor-related amount of $27.57. This amount multiplied by the annual wage index for this facility of 0.923 yields an adjusted labor-related amount of $25.45. The non-labor related portion is 40% of the APC rate or $18.38. The sum of the labor and non-labor related amounts is $43.83. 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 $43.83. This amount multiplied by 200% yields a MAR of $87.66.
- Procedure code 27822 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 0063, which, per OPPS Addendum A, has a payment rate of $3,763.94. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,258.36. This amount multiplied by the annual wage index for this facility of 0.923 yields an adjusted labor-related amount of $2,084.47. The non-labor related portion is 40% of the APC rate or $1,505.58. The sum of the labor and non-labor related amounts is $3,590.05 at 3 units, with multiple-procedure discount, is $7,180.10. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.18. This ratio multiplied by the billed charge of $7,604.47 yields a cost of $1,368.80. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $7,180.10 divided by the sum of all APC payments is 99.04%. The sum of all packaged costs is $1,173.98. The allocated portion of packaged costs is $1,162.76. This amount added to the service cost yields a total cost of $2,531.56. The cost of these services exceeds the annual fixed-dollar threshold of $2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total Medicare facility specific reimbursement amount for this line is $7,180.10. This amount multiplied by 200% yields a MAR of $14,360.20.
- Procedure code 1480 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7030 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1170 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 93005, date of service February 15, 2013, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0099, which, per OPPS Addendum A, has a payment rate of $26.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $16.00. This amount multiplied by the annual wage index for this facility of 0.923 yields an adjusted labor-related amount of $14.77. The non-labor related portion is 40% of the APC rate or $10.67. The sum of the labor and non-labor related amounts is $25.44. 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 $25.44. This amount multiplied by 200% yields a MAR of $50.88.

4. The total allowable reimbursement for the services in dispute is $14,509.85. The amount previously paid by the insurance carrier is $0.00. The requestor is seeking additional reimbursement in the amount of $7,152.12.

This amount is recommended.

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 $7,152.12.

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 $7,152.12, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		March 17, 2014
Signature	Medical Fee Dispute Resolution Officer	Date
		March 17, 2014
Signature	Medical Fee Dispute Resolution Manager	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.