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
SHANNON MEDICAL CENTER

Respondent Name
MANUFACTURERS ALLIANCE INSURANCE COMPANY

MFDR Tracking Number
M4-16-3026-01

Carrier's Austin Representative
Box Number 48

MFDR Date Received
June 03, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have attached the UB along with medical records and proof of timely filing for the claim. . . . This claim was submitted timely to the carrier, well within the 95 day rule and should have processed for payment."

Amount in Dispute: $291.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier denied this treatment on the grounds that the medical records indicated that Claimant was injured at home. [EXHIBIT A]. Carrier additionally continues to deny payment of this claim because emergency room treatment for knee pain was not reasonable and necessary."

Response Submitted by: Brown Sims

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 6, 2015	Outpatient Hospital Emergency Department Evaluation & Management Code 99283	$291.98	$291.98

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §133.20 sets out guidelines for medical bill submission by health care providers.
4. 28 Texas Administrative Code §133.210 sets out guidelines regarding medical documentation.
5. 28 Texas Administrative Code §133.240 sets out guidelines regarding medical payments and denials.

6. 28 Texas Administrative Code §19.2010 sets out requirements prior to issuing an adverse determination.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – BILLED DATE EXCEEDS 95 DAYS FROM DATE OF SERVICE
   - 19 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Does the respondent's position statement address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed?
2. Are the insurance carrier's reasons for denial of payment supported?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent's position statement raises new denial reasons or defenses that were not listed among those presented on the submitted explanations of benefits.

   The respondent's position statement asserts, "Carrier denied this treatment on the grounds that the medical records indicated that Claimant was injured at home. [EXHIBIT A]."

   Review of the carrier's exhibit A finds that the submitted form PLN 11 NOTICE OF DISPUTED ISSUE(S) AND REFUSAL TO PAY BENEFITS regarding the extent of compensable injury is dated June 15, 2016. This date is after the date the request for medical fee dispute resolution was received by the Division on June 3, 2016.

   28 Texas Administrative Code §133.307(d)(2)(B) requires that the respondent shall provide any missing information not provided by the requestor and known to the respondent, including a paper copy of all initial and appeal EOBs related to the dispute, not submitted by the requestor. Subparagraph (D) further requires the respondent to provide a copy of any pertinent medical records or other documents relevant to the fee dispute not already provided by the requestor.

   The respondent did not provide copies of any explanations of benefits indicating denial of payment based on compensability or extent. The respondent did not provide any documentation to support that the health care provider had been informed of a defense related to compensability or extent of injury prior to the filing of the request for medical fee dispute resolution. The Division finds this to be a newly raised defense not previously raised during the bill review process.

   The respondent further asserts, "Carrier additionally continues to deny payment of this claim because emergency room treatment for knee pain was not reasonable and necessary."

   Review of the submitted documentation finds no explanations of benefits or other information to support that the health care provider was informed of the carrier's denial reason or defense on the grounds of the reasonableness or medical necessity of the disputed health care prior to the filing of the request for MFDR.

   Nor did the respondent provide documentation to support notice of an adverse determination—or that they had met the requirements prior to issuing an adverse determination in accordance with 28 Texas Administrative Code §133.240(q), which provides that when the insurance carrier questions the medical necessity or appropriateness of health care, it must meet the requirements of 28 Texas Administrative Code §19.2010, including the requirement that prior to issuing an adverse determination the insurance carrier must give the health care provider a reasonable opportunity to discuss the billed health care with a doctor.

   28 Texas Administrative Code §133.307(d)(2)(F) states 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." As no documentation was found to support that the respondent presented the above denial reasons to the requestor prior to the date the request for medical fee dispute resolution was filed, the Division concludes that the respondent has waived the right to raise such additional defenses during medical fee dispute. Consequently, these newly raised denial reasons or defenses will not be considered in this review.

2. The insurance carrier denied disputed services with claim adjustment reason code 29 – "BILLED DATE EXCEEDS 95 DAYS FROM DATE OF SERVICE."

   28 Texas Administrative Code §133.20 requires that "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   The date of service is June 6, 2015. The requestor provided convincing information to support receipt of the medical bill by the insurance carrier's third party administrator on August 27, 2015. This date is before the 95th day after the date the services were provided.

   Per 28 Texas Administrative Code §133.210(e), "It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other."

   Based on the preponderance of evidence presented by the parties, the Division concludes the health care provider met the timely filing requirement to submit the medical bill within 95 days of the date the services were provided.

   The insurance carrier's denial reason is not supported; consequently, the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.

3. This dispute regards outpatient hospital emergency department evaluation and management services 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.

   Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure codes billed and supporting documentation. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available from the Centers for Medicare and Medicaid Services (CMS). Reimbursement for the disputed services is calculated as follows:

   - Procedure code 99283 has status indicator V denoting a clinic or emergency department visit classified under APC 0614, which, per OPPS Addendum A, has a payment rate of $198.39. This amount multiplied by 60% yields an unadjusted labor-related amount of $119.03. This amount multiplied by the annual wage index for this location of 0.866 yields an adjusted labor-related amount of $103.08. The non-labor related portion is 40% of the APC rate, or $79.36. The sum of the labor and non-labor related amounts is $182.44. This service does not qualify for outlier payment. The total Medicare facility specific reimbursement amount is $182.44, multiplied by the DWC multiplier of 200% yields a MAR of $364.88.

4. The total recommended payment for the services in dispute is $364.88. The insurance carrier has paid $0.00. The requestor is seeking $291.98. 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 $291.98.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $291.98, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	June 29, 2016
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 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 MFDR 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.