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
TEXAS HEALTH ALLEN

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE

MFDR Tracking Number
M4-18-0183-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
September 22, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not include a position statement for review with this request.

Amount in Dispute: $1,024.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the Date(s) of service exceed (95) day time period for submission per Rule 408.027 and Bulletin No. B-0037-05A. The documentation submitted by the provider has been reviewed and fails to meet the guidelines for timely submission."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
October 6, 2016 to October 10, 2016	Outpatient Hospital Services	$1,024.00	$245.72

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 §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - **BFO6** – DATE(S) OF SERVICE EXCEED (95) DAY TIME PERIOD FOR SUBMISSION PER RULE 408.027 AND BULLETIN NO. B-0037-05A.
   - **W3** – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PRO
   - **193** – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.
   - **Z652** – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.

Issues

1. Did the health care provider timely submit the medical bill(s) to the insurance carrier?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the disputed services with claim adjustment reason code: BFO6 – "DATE(s) of service exceed (95) day time period for submission per rule 408.027 and bulletin no. B-0037-05a."

   28 Texas Administrative Code §133.20(b) requires that "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   Review of the submitted information finds that the health care provider submitted the medical bills electronically the insurance carrier. The documentation supports that on October 26, 2016, the provider "Created claim packet and electronically submitted claim to Liberty Mutual." The requestor also provided information to support carrier receipt on October 27, 2016, at 10:03 AM documenting "Electronic Response received from LIBERTY MUTUAL." The response received was "Claim Submission Accepted."

   The above submission and acceptance dates are within 95 days from the dates of service.

   Based on the preponderance of evidence presented to MFDR, the division concludes the requestor has supported timely bill submission to the insurance carrier within the time limit required by Rule §133.20(b). Accordingly, the insurance carrier's denial reasons are not supported—the provider has not forfeited the right to payment and the disputed services may be reviewed for payment according to applicable division rules and fee guidelines.

2. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403. Medicare OPPS formulas and factors are available from http://www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 97010 represents a bundled item for which reimbursement is included in the payment for other services rendered to which this code is incident.
   - Procedure code 97110, billed October 6, 2016, has status indicator A, denoting services paid by fee schedule. Rule §134.403(h) requires use of the DWC Professional Medical Fee Guideline, Rule §134.203(c) for this therapy service. Per Medicare policy, when more than one unit of designated therapy services is billed on the same day, the first unit of the procedure with the highest practice expense is paid in full. Payment for the practice expense of each subsequent unit is reduced by 50%. This procedure has the highest practice expense for this date. The Medicare rate for this code for 2016 is $31.21. Each additional unit is paid at $23.96. Medicare's rate for 2 units is $55.18, divided by the Medicare conversion factor of 35.8279 and multiplied by the DWC conversion factor of 56.82 for a MAR of $87.51.
   - Procedure code 97110, billed October 10, 2016, has status indicator A, denoting services paid by fee schedule. Rule §134.403(h) requires use of the DWC Professional Medical Fee Guideline, Rule §134.203(c) for this therapy service. Per Medicare policy, when more than one unit of designated therapy services is billed on the same day, the first unit of the procedure with the highest practice expense is paid in full. Payment for the practice expense of each subsequent unit is reduced by 50%. This procedure has the highest practice expense for this date. The Medicare rate for this code for 2016 is $31.21. Each additional unit is paid at $23.96. Medicare's rate for 2 units is $55.18, divided by the Medicare conversion factor of 35.8279 and multiplied by the DWC conversion factor of 56.82 for a MAR of $87.51.
   - Procedure code 97140, billed October 6, 2016, has status indicator A, denoting services paid by fee schedule. Rule §134.403(h) requires use of the DWC Professional Medical Fee Guideline, Rule §134.203(c) for this therapy service. As stated above, payment for the practice expense of each subsequent therapy unit is reduced by 50%. This procedure does not have the highest practice expense for this date. The reduced rate for this code for 2016 is $22.29, divided by the Medicare conversion factor of 35.8279 and multiplied by the DWC conversion factor of 56.82 for a MAR of $35.35.

- Procedure code 97140, billed October 10, 2016, has status indicator A, denoting services paid by fee schedule. Rule §134.403(h) requires use of the DWC Professional Medical Fee Guideline, Rule §134.203(c) for this therapy service. As stated above, payment for the practice expense of each subsequent therapy unit is reduced by 50%. This procedure does not have the highest practice expense for this date. The reduced rate for this code for 2016 is $22.29, divided by the Medicare conversion factor of 35.8279 and multiplied by the DWC conversion factor of 56.82 for a MAR of $35.35.

3. The total recommended reimbursement for the disputed services is $245.72. The insurance carrier has paid $0.00, leaving an amount due to the requestor of $245.72. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

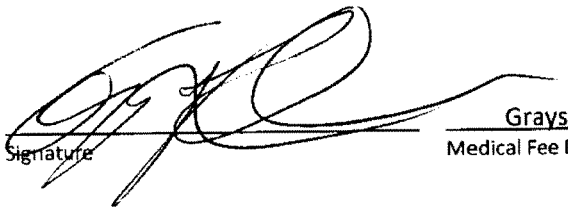
The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though all the evidence was not discussed, it was considered.

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 $245.72.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $245.72, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature



Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

October 13, 2017
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.