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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Medical Center Carrollton

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-18-1082-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 13, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim denied for untimely filing, patient came in Baylor facility as private pay and on 8/24/2017 had provided her work comp insurance information. On 8/25/17 bill went out to Texas Mutual Insurance, on 9/19/2017 received correspondence from Texas Mutual requesting additional information."

Amount in Dispute: $1,695.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual on 9/10/17 received the bill from Baylor Med Ctr Carrollton. …The rationale given by the requestor for the late bill is not consistent with the Rule above. No payment is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 13, 2017	Emergency Room Services	$1,695.37	$442.78

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 Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
3. 28 Texas Administrative Code §133.20 sets out the billing requirements for workers compensation health care claim submission.
4. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired

- 243 – Services not authorized by network/primary care provider
- 727 – Provider no approved to treat Texas Star Network claimant
- 724 – No additional payment after a reconsideration of services

Issues

1. Did the out-of-network healthcare provider meet the requirements of Chapter §1305.006?
2. Did the requestor bill in accordance with 28 Texas Administrative Code §134.20 (b)?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor billed for outpatient hospital services rendered on April 13, 2017 to an injured employee enrolled in the Texas Star Network, a certified healthcare network. The insurance carrier's response indicates that the claim is in the Texas Star Network. The requestor seeks a decision from the Division's medical fee dispute resolution (MFDR) section as an out-of-network healthcare provider.

   The insurance carrier denied/reduced the disputed charges with denial reason code "243 – Services not authorized by network/primary care provider," and "727 – Provider not approved to treat Texas Star Network claimant."

   The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation to resolve matters involving employees enrolled in a certified health care network, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 and limited application of Texas Labor Code statutes and rules, including 28 Texas Administrative Code §133.307.

   Chapter §1305.006 outlines the insurance carrier's liability for out-of-network healthcare and states, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:

   (1) emergency care;
   (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
   (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103.

   Review of the submitted documentation documents that the disputed services are "Emergency" services rendered on April 13, 2017. The Divisions medical fee dispute resolution section, may address disputes involving health care provided to an injured employee enrolled in an HCN, only if the out-of-network services were provided pursuant Chapter §1305.006. The Division finds that the requestor has therefore, met the exception outlined in Chapter 1305.006(1). As a result, the disputed services are under the jurisdiction of the Division of Workers' Compensation and therefore, eligible for medical fee dispute resolution. The disputed services are reviewed pursuant to the applicable rules and guidelines, pursuant to Texas Insurance Code §1305.153(c).

   Texas Insurance Code §1305.153 (c) provides "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

2. For the outpatient services rendered on April 13, 2017, the insurance carrier denied the disputed services with denial reason code(s): "29 – The time limit for filing has expired."

   28 Texas Administrative Code §133.20 (b) states in pertinent part,

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. 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.

Review of the submitted documents found the following;

- The injured worker contacted the requestor on August 24, 2017 to inform them of the correct workers compensation carrier and claim number.
- A completed CMS 1450 with a creation date of September 10, 2017 was found within MFDR documentation packet
- Texas Mutual contacted the supplier on September 14, 2017 seeking a CMS approved form be completed and sent.
- A remittance advice dated September 27, 2017 was found within MFDR documentation packet

Based on the above, the requestor met the requirements of 28 Texas Administrative Code §133.20(b) as they did submit the medical bill within 95 days after they were notified of the correct worker's compensation carrier.

For the reasons stated above the Division finds that insurance carrier's denial reasons are not supported and the requestor is entitled to reimbursement for the disputed services. The services in dispute will be reviewed per the applicable fee guidelines.

3. This dispute regards outpatient hospital services with reimbursement subject to the division's *Hospital Facility Fee Guideline—Outpatient*, at 28 Texas Administrative Code §134.403, which requires the maximum allowable reimbursement (MAR) be calculated using the Medicare facility specific amount (including outlier payments) as determined by the applicable Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors, published annually in the Federal Register, with modifications as set forth in the rules.

   Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and for services without procedure codes is packaged into the APC payment. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

   Rule §134.403(f)(1) requires that the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 36415 has status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
   - Procedure code 80053 has status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
   - Procedure code 85025 has status indicator Q4, denoting packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.

- Procedure code 99282 has status indicator J2, denoting hospital, clinic or emergency room visits (including observation/critical care services) subject to composite payment if certain other services are billed in combination. This is assigned APC 5022. The OPPS Addendum A rate is $111.47, which is multiplied by 60% for an unadjusted labor-related amount of $66.88, in turn multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $65.50. The non-labor related portion is 40% of the APC rate, or $44.59. The sum of the labor and non-labor portions is $110.09. The cost of services does not exceed the fixed-dollar threshold of $3,825. The outlier payment is $0. The Medicare facility specific amount of $110.09 is multiplied by 200% for a MAR of $220.18.
- Procedure code 93971 has status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This is assigned APC 5522. The OPPS Addendum A rate is $112.69, which is multiplied by 60% for an unadjusted labor-related amount of $67.61, in turn multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $66.22. The non-labor related portion is 40% of the APC rate, or $45.08. The sum of the labor and non-labor portions is $111.30. The cost of services does not exceed the fixed-dollar threshold of $3,825. The outlier payment is $0. The Medicare facility specific amount of $111.30 is multiplied by 200% for a MAR of $222.60.

4. The total recommended reimbursement for the disputed services is $442.78. The insurance carrier has paid $0.00 leaving an amount due to the requestor of $442.78. 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 $442.78.

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 $442.78, 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 4, 2018 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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. **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.