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
TX HEALTH FLOWER MOUND

Respondent Name
TEXAS HOSPITAL INSURANCE EXCHANGE

MFDR Tracking Number
M4-18-2011-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
February 9, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This bill was submitted multiple times within the timely filing deadline."

Amount in Dispute: $15,763.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor has provided no valid proof of submission per the 95 day billing rule time requirement."

Response Submitted by: Injury Management Organization, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 19, 2017 to May 21, 2017	Inpatient Hospital Services	$15,763.53	$15,450.66

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 §134.404 sets out the acute care hospital fee guideline for inpatient services.
3. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
4. 28 Texas Administrative Code §133.210 sets out rules regarding processing of medical documentation.
5. Texas Labor Code §408.0272 provides certain exceptions for untimely submission of a medical bill.
6. Texas Labor Code §413.0511 and §413.0512 provide for review of medical quality in worker's compensation.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3 – [No description of this reason code was found with the submitted materials.]
   - Notes: DOCUMENTATION PROVIDED DID NOT ESTABLISH THE RECEIPT OF TIMELY FILING BY THE CARRIER. CONTINUE TO DENY ON APPEAL.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional payment?

Findings

1. Upon reconsideration of the medical bill, the insurance carrier upheld the claim denial for untimely filing with the claim notation: "DOCUMENTATION PROVIDED DID NOT ESTABLISH THE RECEIPT OF TIMELY FILING BY THE CARRIER. CONTINUE TO DENY ON APPEAL."

   The third party claims administrator, responding on behalf of the insurance carrier, asserts, "The requestor has provided no valid proof of submission per the 95 day billing rule time requirement."

   28 Texas Administrative Code §133.20(b) requires that, except as provided in 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."

   28 Texas Administrative Code §133.210(e) in turn states that:

   > 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.

   Review of the submitted information finds sufficient documentation to support, by a preponderance of the evidence, that the health care provider submitted the medical bill to the worker's compensation insurance carrier by mail and by facsimile transmission (fax) within 95 days of the dates of service.

   Consequently, the insurance carrier's denial reasons are not supported. The disputed services will therefore be reviewed for reimbursement in accordance with applicable division rules and fee guidelines.

2. This dispute regards Inpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.404(f), requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Inpatient Prospective Payment System (IPPS) formulas and factors, as published annually in the Federal Register, with modifications set forth in the rules. Medicare IPPS formulas and factors are available from http://www.cms.gov.

   Separate reimbursement for implantables was not requested; accordingly, Rule §134.404(f)(1)(A) requires that, for these services, the Medicare facility specific amount, including any outlier payment, be multiplied by 143%.

   The division establishes the Medicare facility specific amount using the *Medicare Inpatient PPS PC Pricer*, which efficiently identifies facility specific payment factors and adjustments. The Pricer is available from www.cms.gov.

   Note that the "VBP Adjustment" from the Medicare Pricer was removed in calculating the facility specific amount for this admission. Medicare's Value-Based Purchasing (VBP) program is an initiative to improve quality of care in the Medicare system. However, the VBP program conflicts with Texas Labor Code sections 413.0511 and 413.0512, which provide for review and monitoring of health care quality in the Texas Workers' Compensation system. Rule §134.404 (d)(1) requires that specific provisions contained in the Labor Code or division rules take precedence over any conflicting provision used by CMS in administering Medicare. Consequently, the VBP adjustment is not considered in determining the Medicare facility specific amount.

   Review of the submitted medical bill and supporting documentation finds that the DRG code assigned to the disputed services is 517. The services were provided at Texas Health Hospital at Flower Mound. Based on the DRG code, service location, and bill-specific information, the division finds that the Medicare facility specific amount is $10,804.66. This amount multiplied by 143% results in a MAR of $15,450.66.

3. The total recommended payment for the services in dispute is $15,450.66. The insurance carrier has paid $0.00, leaving an amount due to the requestor of $15,450.66. This amount is recommended.

Conclusion

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 not all the evidence was 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 $15,450.66.

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 $15,450.66, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	March 9, 2018
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 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.