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
Baylor University Medical Center

Respondent Name
Dallas County

MFDR Tracking Number
M4-18-2447-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
March 8, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient came in our facility using her group insurance/United healthcare."

Amount in Dispute: $1,370.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent further contends Requestor has not submitted proof satisfactory to the Commissioner that the provider timely but erroneously filed for reimbursement with the group health carrier..."

Response Submitted by: Knott & Doyle

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 11, 2017	Outpatient Hospital Services	$1,370.35	$903.20

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 requirements of submission of medical bills by health care providers.
3. 28 Texas Administrative Code §134.403 sets out the for outpatient hospital reimbursement guidelines.
4. The carrier denied the services in dispute with the following adjustment codes:
    - 29 – The time limit for filing has expired
    - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly

Issues

1. Did the requestor meet exception to timely filing?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional payment?

Findings

1. The requestor is seeking $1,370.35 for outpatient hospital services rendered on June 11, 2017. The insurance carrier denied disputed services with claim adjustment reason code 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), (b), 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. 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.

   Texas Labor Code §408.0272 (b) states,

   > Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:
   >
   > (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
   >
   > (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
   >
   > (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
   >
   > (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
   >
   > (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

   Review of the submitted documentation found a "Comment Text" of "PT states this a W/C no information given" on September 18, 2017. The comment, "PT cld to give w.comp update," was noted on October 27, 2017 and "Carol/York services cld to provide work comp info," on November 3, 2017. These comments support an exception described in Texas Labor Code 408.0272 (b) exists. A remittance advice from United Healthcare dated 08/24/2017 supports the claim was submitted to the injured employee's health insurance.

   Therefore, as the "Explanation of Review" from York shows "Carrier Received: 11/16/17." This submission was within 95 days of the providers' notification of the correct workers compensation insurance. The carriers' denial is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.403 (d) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

28 Texas Administrative Code §134.403 (f) states in pertinent part,

> The reimbursement calculation used for establishing the 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. The following minimal modifications shall be applied.
>
> (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
>
> (A) 200 percent;

Reimbursement based on the applicable Medicare payment policy and division rules is found below:

- Procedure code 99282 has status indicator J2, denoting hospital, clinic or emergency visits subject to comprehensive packaging if 8 or more hours observation billed as the criteria for comprehensive packaging is not met, this code is assigned APC 5022. The OPPS Addendum A rate is $111.47. This is multiplied by 60% for an unadjusted labor-related amount of $66.88, which is 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 12041 has status indicator Q2, denoting T-packaged codes; reimbursement is packaged with payment for any service with status indicator T. This code is assigned APC 5052. The OPPS Addendum A rate is $292.62. This is multiplied by 60% for an unadjusted labor-related amount of $175.57, which is multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $171.95. The non-labor related portion is 40% of the APC rate, or $117.05. The sum of the labor and non-labor portions is $289.00. 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 $289.00 is multiplied by 200% for a MAR of $578.00.
- Procedure code 96372 has status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This code is assigned APC 5692. The OPPS Addendum A rate is $53.17. This is multiplied by 60% for an unadjusted labor-related amount of $31.90, which is multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $31.24. The non-labor related portion is 40% of the APC rate, or $21.27. The sum of the labor and non-labor portions is $52.51. 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 $52.51 is multiplied by 200% for a MAR of $105.02.
- Procedure code 90715 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.

3. The total recommended reimbursement for the disputed services is $903.20. The insurance carrier has paid $0.00 leaving an amount due to the requestor of $903.20. 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 $903.20

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 $903.20, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		April 6, 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.