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
Doctors Hospital at Renaissance

Respondent Name
WC Solutions

MFDR Tracking Number
M4-18-4221-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 9, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On August 17, 2017 we received call from BCBS requested refund and mentioned this service is under work related injury with Edward Claims called advising us to submit to worker compensation due to work related injury. As proof that claim was billed and processed by BCBS, a copy of the explanation of benefits along with the claim, itemized bill and medical records."

Amount in Dispute: $400.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The documentation submitted did not provide convincing evidence to support the position that this bill was submitted timely to the Workers' Compensation carrier."

Response Submitted by: Starr Comprehensive Solutions Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 17, 2016	70260, 73110, 73130	$400.06	$390.92

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 §133.302 sets out filing deadlines for submission of healthcare bills.
3. Texas Labor Code 408.0272 details exceptions to filing deadlines.
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

- 193 – Original payment decision is being maintained

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment for the services in dispute?

Findings

1. The requestor is seeking $400.06 for outpatient services rendered on August 16, 2016. 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,

> (b) 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. 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) and (c) states in pertinent part,

> (b) 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;
> >
> > (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.
>
> (c) Notwithstanding Subsection (b), a health care provider who erroneously submits a claim for payment to an entity described by Subdivision (1) of that subsection forfeits the provider's right to reimbursement for that claim if the provider fails to submit the claim to the correct workers' compensation insurance carrier within 95 days after the date the provider is notified of the provider's erroneous submission of the claim

The requestor states, "On August 17, 2017 we received call from BCBS requested refund and mentioned this service is under work related injury with Edward Claims…" Review of the submitted documentation finds;

- CMS 1450 dated August 17, 2017 indicating WC Edward Claim
- Explanation of benefits from Star Comprehensive Solutions Inc with audit date of October 27, 2017.

Per specifications of Texas Labor Code 408.0272 (c) the requestor did submit the claim to the workers compensation carrier within 95 days of notification. The services in dispute will be reviewed per Division rules and fee guidelines.

2. 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 (f)(1) requires that the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent, unless a facility or surgical implant provider requests separate payment of implantables. This medical bill does not contain a request for implantables and the fee calculations will be based on the Medicare facility specific amount multiplied by 200 percent

   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.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 70260 has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for any procedures with status indicator S, T or V. These services are separately payable only if no other such procedures are billed. This is assigned APC 5522. The OPPS Addendum A rate is $100.69. This is multiplied by 60% for an unadjusted labor-related amount of $60.41, which is multiplied by the facility wage index of 0.7989 for an adjusted labor amount of $48.26. The non-labor related portion is 40% of the APC rate, or $40.28. The sum of the labor and non-labor portions is $88.54. The Medicare facility specific amount of $88.54 is multiplied by 200% for a MAR of $177.08.
   - Procedure code 73110 has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for any procedures with status indicator S, T or V. These services are separately payable only if no other such procedures are billed. This is assigned APC 5521. The OPPS Addendum A rate is $60.80. This is multiplied by 60% for an unadjusted labor-related amount of $36.48, which is multiplied by the facility wage index of 0.7989 for an adjusted labor amount of $29.14. The non-labor related portion is 40% of the APC rate, or $24.32. The sum of the labor and non-labor portions is $53.46. The Medicare facility specific amount of $53.46 is multiplied by 200% for a MAR of $106.92.
   - Procedure code 73130 has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for any procedures with status indicator S, T or V. These services are separately payable only if no other such procedures are billed. This is assigned APC 5521. The OPPS Addendum A rate is $60.80. This is multiplied by 60% for an unadjusted labor-related amount of $36.48, which is multiplied by the facility wage index of 0.7989 for an adjusted labor amount of $29.14. The non-labor related portion is 40% of the APC rate, or $24.32. The sum of the labor and non-labor portions is $53.46. The Medicare facility specific amount of $53.46 is multiplied by 200% for a MAR of $106.92.

3. The total recommended reimbursement for the disputed services is $390.92. The insurance carrier has paid $0.00 leaving an amount due to the requestor of $390.92. 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 $390.92.

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 $390.92, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Peggy Miller	August 2, 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.