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 MEDICAL CENTER MCKINNEY

Respondent Name
ZURICH AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-18-4241-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 6, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim had denied twice for untimely filing. Patient came in Baylor facility using [the injured employee's group health insurance information]. On 11/17/2017 the employer . . . called and provided patient work comp insurance information."

Amount in Dispute: $20,127.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier did reimburse the provider in accordance with the medical fee guidelines. . . . However, that recommendation and payment was in despite of the fact that the carrier has an absolute defense under §408.027(a) to deny the bill."

Response Submitted by: Flahive, Odgen & Latson, Attorneys At Law, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
July 6, 2017 to July 7, 2017	Outpatient Hospital Services	$20,127.02	$0.00

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 §134.403 sets out the hospital facility fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED
   - 4271 - PER TX LABOR CODE SEC. 413.016, PROVIDERS MUST SUBMIT BILLS TO PAYORS WITHIN 95 DAYS OF THE DATE OF SERVICE.
   - OA – The amount adjusted is due to bundling or unbundling of services.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

- 1014 - THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
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 disputed services with claim adjustment reason codes:
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED
   - 4271 - PER TX LABOR CODE SEC. 413.016, PROVIDERS MUST SUBMIT BILLS TO PAYORS WITHIN 95 DAYS OF THE DATE OF SERVICE.

   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."

   Texas Labor Code §408.027(a) states, "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   Texas Labor Code §408.0272(b) allows certain exceptions to the 95 day filing limit, a health care provider does not forfeit the right to reimbursement 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.

   The respondent asserts, "the carrier has an absolute defense under §408.027(a) to deny the bill." The response states further that "the UB-04 was not created within 95 days of the date of service. . . . There is no proof that the provider submitted a claim to any entity other than to Zurich American Insurance Company and that claim was submitted well after 95 days following the dates of services."

   The provider asserts, "Patient came in Baylor facility using [the injured employee's group health insurance information]. On 11/17/2017 the employer . . . called and provided patient work comp insurance information."

   Review of the submitted information finds that the dates of service in dispute are July 6, 2017 to July 7, 2017. The provider included a remittance advice with explanation of benefits (EOB) from the injured employee's group health insurance carrier with a remit date of July 17, 2017, which is proof satisfactory to the division that the bill had been submitted electronically to the injured employee's group health insurance within 95 days of the dates of service in accordance with the exception provided in Labor Code §408.027(b)(1)(A).

   The respondent argues, "since the UB-04 was not created until November 20, 2017, that submission would have already surpassed the 95 day limit."

   The division notes the provider stated the workers' compensation information was given to them November 17th. The November 20th creation date on the bill thus clearly reflects the date the paper bill was generated to send to the *workers' compensation* carrier. The bill was initially sent electronically to the group health insurance — as shown by that carrier's remittance advice, dated July 17, 2017. Because the bill was transmitted electronically to the group health insurance, no paper bill was generated for submission to that carrier.

   The respondent's denial reasons are not supported and found to be without merit. Consequently, the disputed services will be reviewed for reimbursement per applicable division rules and fee guidelines.

2. This dispute regards outpatient facility services with payment subject to 28 Texas Administrative Code §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors published in the Federal Register, with modifications set out in the rules. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200 percent for these disputed emergency room services.

   Medicare assigns an Ambulatory Payment Classification (APC) to OPPS services based on billed procedure codes and supporting documentation. The APC determines the payment rate. Reimbursement for ancillary items and services is packaged with the APC payment. CMS publishes quarterly APC rate updates, available at www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 99285 has status indicator J2, denoting outpatient visits subject to comprehensive packaging if 8 or more hours of observation are billed. More than 8 hours of observation were billed under code G0378. Per Medicare payment policy, when criteria are met, all line items on the claim (with certain limited exclusions not present on the bill) are packaged together as a single comprehensive service paid under APC 8011 (Comprehensive Observation Services). The OPPS Addendum A rate for APC 8011 of $2,222.64 is multiplied by 60% for an unadjusted labor amount of $1,333.58, in turn multiplied by the facility wage index of 0.9794 for an adjusted labor amount of $1,306.11. The non-labor portion is 40% of the APC rate, or $889.06. The cost of services does not meet the threshold for outlier payment. The sum of the labor and non-labor portions is the Medicare facility specific amount of $2,195.17, which is multiplied by 200% for a MAR of $4,390.34.
   - Payment for all other services on the bill is packaged with the primary comprehensive J2 service according to Medicare policy regarding comprehensive APCs. Reimbursement for all items is included in the payment for the primary procedure. Please see *Medicare Claims Processing Manual* Chapter 4 §10.2.3 for further details.

3. The total recommended reimbursement for the disputed services is $4,390.34. After the filing of the request for medical fee dispute resolution, the insurance carrier reprocessed the bill and issued payment of $4,390.34, leaving a balance due to the requestor of $0.00. Additional payment is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	August 10, 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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.