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
OAKBEND MEDICAL CENTER

Respondent Name
SERVICE LLOYDS INSURANCE COMPANY

MFDR Tracking Number
M4-18-5047-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
August 20, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "a corrected claim was sent to reflect the changes that were requested by WCI Service Lloyds' adjuster but it was perceived as a duplicate claim and thus denied…. They also stated that the extent of injury and with the diagnosis … were not covered. Oakbend has provided appropriate documentation so that these diagnoses should be covered… The provider exercised due diligence to verify coverage … Importantly, the insurer provided no advance notice of a potential denial of outpatient coverage."

Amount in Dispute: $45,342.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The denial for timely filing is being upheld."

Response Submitted by: Mitchell International, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 16, 2017	Outpatient Hospital Services	$45,342.25	$10,981.46

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 §124.2 sets out requirements for carrier reporting and notification.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
4. 28 Texas Administrative Code §133.240 sets out requirements regarding medical bill payments and denials.
5. 28 Texas Administrative Code §133.500 establishes formats for electronic medical bill processing.
6. 28 Texas Administrative Code §133.501 sets out requirements for electronic medical bill processing.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 219 – BASED ON EXTENT OF INJURY.
   - 751 – EXTENT OF INJURY NOT FINALLY ADJUDICATED.
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Was the request for Medical Fee Dispute Resolution (MFDR) timely filed with the division?
2. Are there any outstanding issues of compensability, extent of injury or liability for the claim?
3. Did the respondent raise new issues or defenses in their position statement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) requires that a requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. Rule §133.307(c)(1)(A) further requires a request for MFDR, that does not meet certain exceptions listed in Rule §133.307(c)(1)(B), to be filed no later than one year after the date(s) of service in dispute.

   The date of the services in dispute is August 16, 2017. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on August 20, 2018. This date is later than one year after the date(s) of service in dispute.

   However, the requestor is located in Fort Bend County. This was a county impacted by Hurricane Harvey and subject to the Governor's disaster proclamation of August 23, 2017. Pursuant to the Commissioner of Worker's Compensation Bulletin #B-0020-17, issued August 29, 2017, for system participants in affected counties, all deadlines with respect to claim notification and filing, medical billing, medical and income benefit payments, electronic data reporting, and medical and income benefit disputes are tolled (suspended) through the duration of the Governor's disaster proclamation. Pursuant to Commissioner's Bulletin # B-0042-17, the tolling period was lifted on January 10, 2018, with the effect that the 'clock' for making a required filing resumed 'ticking' on the effective date the tolling period ended.

   Review of the submitted documentation finds 8 days had transpired between the date of service (August 16, 2017) and the Governor's proclamation of August 23, 2017. An additional 222 days elapsed after expiration of the tolling period on January 10, 2018 until the filing of the dispute request with MFDR on August 20, 2018—for a total of 230 days. This is within the one-year filing limit provided in Rule §133.307(c)(1)(B) as extended by the Governor's proclamation. Consequently, the division concludes the requestor has timely filed the request for MFDR and this dispute is thus eligible for review.

2. The insurance carrier denied payment with claim adjustment reason codes:
   - 219 – BASED ON EXTENT OF INJURY.
   - 751 – EXTENT OF INJURY NOT FINALLY ADJUDICATED.

   Rule §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

   Rule §133.307(d)(2)(H) further requires that If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

   The respondent did not submit copies of any PLN-11 or plain language notices issued in accordance with Rule §124.2, as required by Rule $133.307(d)(2)(H). The carrier thus failed to meet the requirements of Rule §133.307(d)(2)(H) regarding any issues of extent of injury and has waived the right to raise such issues.

   Based on the submitted information, the denial reason codes regarding extent of injury are not supported. Consequently, the division concludes there are no outstanding issues of extent of injury. Accordingly, the disputed services are eligible for review in accordance with division rules and fee guidelines.

3. In their response to this dispute, the respondent states, "the denial for timely filing is being upheld."

   28 Texas Administrative Code §133.240 requires the insurance carrier to send an explanation of benefits to the health care provider when the insurance carrier makes or denies payment on a medical bill.

   Rules §§ 133.240 (e) and (f) set out required elements an EOB must contain, including, per §§ 133.240(f)(17)(G) and (H), adjustment reason code(s) conforming to the standards described in Rules §133.500 and §133.501 if the total amount paid does not equal the total amount charged; with explanation of the reason(s) for reduction or denial for any code used to adjust the payment.

   Rule §133.307(d)(2)(B) requires that upon receipt of the request for medical fee dispute resolution, the respondent shall provide any missing information not provided by the requestor and known to the respondent, including:

   > a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider . . . related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request.

   Review of the copies of explanations of benefits submitted by both the requestor and the respondent finds no denial code relating to timely filing.

   Rule §133.307(f) provides that:

   > The division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the division no later than 14 days after receipt of this request. If the division does not receive the requested additional information within 14 days after receipt of the request, then the division may base its decision on the information available.

   Pursuant to Rule §133.307(f)(1), on September 13, 2018, the division requested the respondent to provide copies of any EOBs issued by the carrier relating to denial for failure to timely submit the medical bill. As of the date of review, the respondent has not submitted any additional evidence for consideration. Consequently, the findings in this decision are based on the information available at the time of review.

   Rule §133.307(d)(2)(F) requires that:

   > The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

   Pursuant to Rule §133.307(d)(2)(F), the insurance carrier's failure to give notice to the health care provider of specific codes or explanations for reduction or denial of payment as required by Rule §133.240 constitutes grounds for the division to find a waiver of defenses during Medical Fee Dispute Resolution.

   The division notes further that the provider's deadlines to submit the bill to the carrier were also extended by the Governor's Hurricane Harvey proclamation (discussed above) and that the 95th day after the date of service would have fallen during the period that such deadlines were suspended.

   Upon review of the insurance carrier response, the division finds the respondent has raised new denial reasons or defenses of which the carrier failed to give notice to the health care provider during the bill review process or prior to the filing of this dispute. Consequently, the division concludes the insurance carrier has waived the right to raise these new denial reasons or defenses during MFDR. Any such new defenses or denial reasons will not be considered in this review.

4. This dispute regards outpatient facility services subject to DWC's *Hospital Facility Fee Guideline*, Rule §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, as modified by DWC rules. Rule §134.403(f)(1) requires the Medicare facility amount and any outlier payment be multiplied by 200% for the disputed services. Separate reimbursement for implants was not requested.

   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 codes J7120, C1713, J0330, J1100, J2405, J3010, J2250, J2704, and J1170 have status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.
- Procedure code 29827 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5114. The OPPS Addendum A rate is $5,221.57, multiplied by 60% for an unadjusted labor amount of $3,132.94, in turn multiplied by the facility wage index of 0.9653 for an adjusted labor amount of $3,024.23. The non-labor portion is 40% of the APC rate, or $2,088.63. The sum of the labor and non-labor portions is $5,112.86. Per 42 Code of Federal Regulations §419.43(d) and *Medicare Claims Processing Manual*, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the fixed-dollar threshold of $3,825, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. There is only one separately paid line item on this bill; all packaged costs are allocated to this item at 100%. The Medicare OPPS Facility-Specific Impacts file for 2017 lists the cost-to-charge ratio for this provider as 0.214. This ratio is multiplied by the total packaged charges of $45,342.25, giving a total cost of $9,703.25. The cost of services exceeds the fixed-dollar threshold of $3,825. The amount by which the cost exceeds 1.75 times the OPPS payment is $755.74. The outlier payment is half of this amount, or $377.87. The Medicare facility specific amount (including outlier payment) of $5,490.73 is multiplied by 200% for a MAR of $10,981.46.

The total recommended reimbursement for the disputed services is $10,981.46. The insurance carrier paid $0.00, leaving an amount due to the requestor of $10,981.46. This amount is recommended.

Conclusion

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available 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 $10,981.46.

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 $10,981.46, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	November 30, 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 division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all parties involved in the dispute at the same time the request is filed. Include a copy of this *Medical Fee Dispute Resolution Findings and Decision* together with any other information required by 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.