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
DOCTORS HOSPITAL AT RENAISSANCE

Respondent Name
ZURICH AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-19-1097-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 26, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "at the time of service patient presented himself with BCBS private insurance. On July 16, 2018 BCBS processed and denied…

Amount in Dispute: $2,260.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 26, 2018	Outpatient Hospital Services	$2,260.80	$1,242.80

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. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
4. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
5. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
6. Texas Labor Code §408.0272 provides certain exceptions for untimely submission of a medical bill.
7. The division provided a copy of the Medical Fee Dispute Resolution request to the insurance carrier's Austin representative, receipt acknowledged November 5, 2018. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier has not responded. Consequently, this decision is based on the information available at the time of review.

8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

1. Was the medical bill submitted to the insurance carrier within the time limits of the rules?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 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) 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 §408.0272(b)(1) provides exceptions to the 95-day time limit for medical bill submission. A health care provider who fails to timely submit a medical bill to the insurance carrier under Section 408.027(a) does not forfeit the right to reimbursement if 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

   The requestor provided documentation to support initially submitting the bill(s) to the employee's group health insurance company. The explanation of benefits (EOB) from the group health insurer indicates receipt of the bill on June 14, 2018. This date is within 95 days from the service date. The group insurer denied the bill on July 12, 2018.

   After the group health insurer denied payment, the hospital billed the workers' compensation carrier, which the compensation carrier's EOB indicates receipt on September 5, 2018. This date is before the 95th day following the date the group health insurer denied the initial billing.

   The division concludes the provider met the exception to the 95-day time limit in Labor Code §408.0272(b)(1)(A). Accordingly, the workers' compensation insurance carrier's denial related to untimely filing is not supported. The disputed services will therefore be reviewed for payment in accordance with division rules and fee guidelines.

2. 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 specific amount and any outlier payment be multiplied by 200% for the disputed facility 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 36415 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
   - Procedure codes 72170, 73030, and 73562 have status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V, which in this case includes both the CT services and evaluation code 99284, detailed below.
   - Procedure code 71045 represents an X-ray service assigned APC 5521. The OPPS Addendum A rate is $62.12, multiplied by 60% for an unadjusted labor amount of $37.27, in turn multiplied by the facility wage index of 0.8289 for an adjusted labor amount of $30.89. The non-labor portion is 40% of the APC rate, or $24.85. The sum of the labor and non-labor portions is the Medicare facility specific amount of $55.74, which is multiplied by 200% for a MAR of $111.48.

- Per Medicare policy regarding Correct Coding Initiative (CCI) edits, procedure code 99284 may not be reported with code 94760 on the same bill; however, separate payment is allowed if a modifier is used appropriately. The requestor billed this code with modifier 25, and the documentation supports the modifier. Separate payment is allowed. This code is assigned APC 5024. The OPPS Addendum A rate is $355.53, multiplied by 60% for an unadjusted labor amount of $213.32, in turn multiplied by the facility wage index of 0.8289 for an adjusted labor amount of $176.82. The non-labor portion is 40% of the APC rate, or $142.21. The sum of the labor and non-labor portions is the Medicare facility specific amount of $319.03. This is multiplied by 200% for a MAR of $638.06.
- Procedure code 94760 has 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 codes 70450, 72125, 72128, and 72131 have status indicator Q3, for packaged codes paid through a composite APC. Codes assigned to composites are major components of a single episode of care; the hospital receives one payment for any combination of designated procedures. These services are assigned composite APC 8005, for computed tomography (CT) services without contrast. If a composite includes multiple lines, the charges for those combined services are summed to one line. To determine outliers, a single cost for the composite is estimated from the summarized charges. Total packaged cost is allocated to the composite line in proportion to other separately paid services on the bill. This line is assigned APC 8005 with status indicator S, for procedures not subject to reduction. The OPPS Addendum A rate is $274.84, multiplied by 60% for an unadjusted labor amount of $164.90, in turn multiplied by the facility wage index of 0.8289 for an adjusted labor amount of $136.69. The non-labor portion is 40% of the APC rate, or $109.94. The sum of the labor and non-labor portions is $246.63. The cost of services does not exceed the threshold for outlier payment. The Medicare facility specific amount of $246.63 is multiplied by 200% for a MAR of $493.26.

The total recommended reimbursement for the disputed services is $1,242.80. The insurance carrier paid $0.00. The amount due is $1,242.80. This amount is recommended.

Conclusion

The requestor has established that additional reimbursement is due. The amount ordered is $1,242.80.

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 $1,242.80, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	January 11, 2019
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.