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
INDEMNITY INSURANCE COMPANY OF NORTH AMERICA

MFDR Tracking Number
M4-19-1416-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
November 9, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "patient came in Baylor facility using … BCBS group health insurance first then requested to bill workers' comp."

Amount in Dispute: $1,884.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent first received the medical bill for date of service 12/4/17 on 5/24/18 … Because the medical bill was received more than 95 days after the date of service, it was denied for lack of timely filing."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
December 4, 2017	Outpatient Hospital – Emergency Room Visit	$1,884.23	$501.38

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 medical bill submission procedures for health care providers.
3. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
4. Texas Labor Code §408.0272 provides certain exceptions for untimely submission of a medical bill.
5. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
6. 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
7. 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. 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.
   - 5094 – DWC requires request for reconsideration or corrected claims to be submitted within 10 months of the date of service.

Issues

1. Did the health care provider fail to timely file the medical bill to the insurance carrier?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with adjustment codes:
   - 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) provides certain exceptions to the 95-day time limit for medical bill submission. A health care provider does not forfeit the right to reimbursement 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

   The requestor states the injured employee gave "BCBS group health insurance first then requested to bill workers' comp." The requestor provided a remittance advice from Blue Cross Blue Shield showing the employee's group health insurer processed the medical bill January 10, 2018. This date is within 95 days from the date of service. The provider has thus supported meeting the exception described in Texas Labor Code §408.0272.

   The division concludes the requestor has not forfeited the right to reimbursement for the medical bill.

2. This dispute regards emergency room 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 these outpatient 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 codes 72100 and 73502 have status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for CPT 96372, assigned status indicator S, billed the same date.
   - Procedure code 99283 has status indicator J2 (outpatient visit). This code is assigned APC 5023. The OPPS Addendum A rate is $201.25. This is multiplied by 60% for an unadjusted labor amount of $120.75, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $117.80. The non-labor portion is 40% of the APC rate, or $80.50. The sum of the labor and non-labor portions is the Medicare facility specific amount of $198.30. This is multiplied by 200% for a MAR of $396.60.
   - Procedure code 96372 has status indicator S (procedure 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 amount of $31.90, in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $31.12. The non-labor portion is 40% of the APC rate, or $21.27. The sum of the labor and non-labor portions is the Medicare facility specific amount of $52.39. This is multiplied by 200% for a MAR of $104.78.
   - Procedure code J1885 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.

The total recommended reimbursement for the disputed services is $501.38. The insurance carrier paid $0.00. The amount due is $501.38. 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 $501.38.

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 $501.38, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	December 7, 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.