



# 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

EAST TEXAS MEDICAL CENTER

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-19-2937-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

January 28, 2019

#### REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This bill was authorized and initially paid by United Health Care... We were notified on 11/16/2018 that the patient has an open Workers' Compensation claim. The UHC Remittance was sent to Texas Mutual with the initial bill to prove timely filing but still denied."

Amount in Dispute: \$7,214.69

#### RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas mutual received the bill on 12/11/18 the 95<sup>th</sup> day would have been 6/10/18, this bill was submitted untimely, documentation submitted in dispute doesn't justify timely submission"

Response Submitted by: Texas Mutual Insurance Company

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 5, 2018 to March 7, 2018	Inpatient Hospital Services	\$7,214.69	\$7,214.69

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### Background

- 28 Texas Administrative Code §124.2 sets out requirements for carrier reporting and notification.
- 28 Texas Administrative Code §124.3 sets out rules for investigating an Injury and giving notice of dispute.
- 28 Texas Administrative Code §133.240 sets out provisions regarding medical payments and denials.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.404 sets out the hospital facility fee guideline for inpatient services.
- Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
- Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
- Texas Labor Code §409.021 sets out requirements for disputing compensability and giving notice of refusal to pay.
- The insurance carrier denied payment for the services with the following claim adjustment reason codes:
  - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED
  - 731 – PER 133.20(B) PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE.

## Issues

1. Are there any outstanding issues related to extent or liability for the disputed injury?
2. Does the respondent's position statement address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed?
3. Did the requestor meet an exception to the 95-day time limit for submitting the bill to the proper carrier?
4. Is the requestor entitled to payment?

## Findings

1. Rule §133.240(h) requires the insurance carrier to file notice as required by Labor Code §409.021 and Rules §124.2 and §124.3 if denying payment based on compensability of, liability for, or relatedness to the disputed injury.

Rule §124.2(h) requires the carrier to notify the division and claimant of a dispute of extent of injury using plain language notices prescribed by the division.

Rule §124.3(e) requires the carrier to file a notice of dispute of extent of injury in accordance with Rule §124.2 not later than the earlier of (1) the date the carrier denied the medical bill; or (2) the due date for the carrier to pay or deny the medical bill as provided in Chapter 133.

Rule §133.240(a) requires an insurance carrier to take final action after conducting bill review on a complete medical bill not later than the 45th day after the date the insurance carrier received a complete medical bill.

The initial explanation of benefits contains no denial reasons related to liability or extent. The respondent's position statement asserts "Texas mutual received the bill on 12/11/18." Rule §124.3(e) required the carrier to file notice of a dispute of extent of injury not later than the earlier of the date it denied the medical bill or the due date for the carrier to pay or deny the bill. Per Rule §134.240(a), the due date to pay or deny a bill is not later than the 45<sup>th</sup> day after the date of receipt. The 45<sup>th</sup> day following the date of receipt of the bill was January 25, 2019. However, the insurance carrier did not issue any notice of dispute of extent of injury until February 14, 2019 — after the 45-day deadline for it to do so.

Review of the submitted documentation finds the insurance carrier failed to timely dispute extent of injury and further failed to timely issue required notice of such dispute in accordance with division rules. Consequently, the division concludes there are no outstanding issues of extent or liability regarding the disputed services.

2. The respondent's position statement raises new defenses or denial reasons that were not presented to the health care provider before the date the request for MFDR was filed with the division and the insurance carrier.

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."

No documentation was provided to support that the respondent presented these new denial reasons to the requestor prior to the date that the request for medical dispute resolution was filed; therefore, the division concludes the respondent has waived the right to raise any such additional denial reasons or defenses.

Any newly raised denial reasons or defenses shall not be considered in this review. Reimbursement for the disputed services will be considered according to applicable division rules and fee guidelines.

3. The insurance carrier denied payment for the disputed services with the following claim adjustment codes:
- 29 – THE TIME LIMIT FOR FILING HAS EXPIRED
  - 731 – PER 133.20(B) PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE.

The requestor asserts “This bill was authorized and initially paid by United Health Care... We were notified on 11/16/2018 that the patient has an open Workers’ Compensation claim. The UHC Remittance was sent to Texas Mutual with the initial bill to prove timely filing but still denied.”

The respondent states “Texas mutual received the bill on 12/11/18 the 95<sup>th</sup> day would have been 6/10/18, this bill was submitted untimely, documentation submitted in dispute doesn’t justify timely submission”

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 certain 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 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;
- (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...

The requestor submitted proof satisfactory to the division that within the prescribed period the health care provider erroneously filed for reimbursement with a group accident and health insurer or health maintenance organization under which the injured employee was covered. Accordingly, the division concludes the requestor has met a listed exception to the 95-day time limit for medical bill submission.

The disputed medical bill will thus be reviewed for payment in accordance with division rules and fee guidelines.

4. This dispute regards inpatient services with payment subject to the *Hospital Facility Fee Guideline—Inpatient*, Rule §134.404, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount (including outlier payments) applying Medicare Inpatient Prospective Payment System (IPPS) formulas and factors with modifications set out in the rule. Medicare IPPS formulas and factors are available from the Centers for Medicare and Medicaid Services at <http://www.cms.gov>.

Separate reimbursement for implantables was not requested; accordingly, Rule §134.404(f)(1)(A) requires that for these services the Medicare facility specific amount, including any outlier payment, be multiplied by 143%.

The division calculates the Medicare facility specific amount using Medicare’s *Inpatient PPS PC Pricer* as a tool to efficiently identify and apply IPPS formulas and factors. This software is also freely available from [www.cms.gov](http://www.cms.gov).

Review of the submitted medical bill and supporting documentation finds the assigned DRG code to be 766. The service location is Tyler, Texas. Based on DRG code, service location, and bill-specific information, the Medicare facility specific amount is \$5,129.17. This amount multiplied by 143% results in a MAR of \$7,334.71.

The total MAR for the services in dispute is \$7,334.71. The insurance carrier paid \$0.00.

The requestor is seeking payment of \$7,214.69. 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 \$7,214.69.

**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 \$7,214.69, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Grayson Richardson  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
February 22, 2019  
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 DWCO45M) 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.