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
TEXAS HEALTH OF PLANO

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-3341-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 4, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient was seen at TX Health Presbyterian Hospital Plano on 03/27/2018 and provided commercial insurance information for procedure … On 11/15/2018, UHC sent letter to the provider stating this claim was to be reimbursed through a workers compensation insurance carrier, Texas Mutual. This was day 233. Claim was billed to the workers compensation insurance on 12/10/2018, TX Mutual … and denied."

Amount in Dispute: $19,939.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "TEXAS HEALTH PLANO states it was notified by a UHC letter of the correct carrier on 11/15/18 but has not provided the letter."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 27, 2018	Outpatient Hospital Services	$19,939.56	$19,939.56

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

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 §134.600 sets out requirements regarding authorization of health care.
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 insurance carrier reduced 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.
   - 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
   - 786 – DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.

- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (800) 859-5995 x3994.
- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Was the medical bill timely submitted to the correct workers' compensation carrier?
2. Are the insurance carrier's denial reasons supported?
3. 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
   - 731 – PER 133.20(B) PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE 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. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill."

   Texas Labor Code §408.0272(b) provides certain exceptions to the 95-day time limit for medical bill submission. A health care provider who fails to timely submit a medical 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 submitted information supports the medical bill was erroneously filed with the injured employee's group health insurance plan, United Healthcare (UHC), within the required time limit. UHC paid the bill, leaving unpaid a portion attributed to patient responsibility, which the injured employee also made payments on.

   A letter from Optum, a recovery agent for UHC, dated November 15, 2018, addressed to Texas Health Presbyterian Hospital seeks recovery for the disputed health care previously paid by UHC due to a workers' compensation incident. The letter advises the provider to present the claim to Texas Mutual for payment. The division finds that November 15, 2018 was the date of notification of the provider's erroneous submission.

   An explanation of benefits from Texas Mutual, audit date December 31, 2018, supports that Texas Mutual received the bill before the 95th day following the date the provider was notified of the proper carrier.

   Accordingly, the division concludes the health care provider has met an exception provided in Labor Code §408.0272 and has timely filed the bill with the correct carrier within the time limit allowed by Rule §133.20.

2. The insurance carrier denied disputed services with claim adjustment code:
   - 786 – DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.

   Based on information maintained by the division, the injured employee's claim is not subject to a workers' compensation health care network (HCN) certified in accordance with Insurance Code Chapter 1305. This denial reason is therefore not supported.

The carrier further denied disputed services with claim adjustment code:

- 197 – PRECERTIFICATION/AUTHORIZATION ABSENT

134.600(c)(1)(B) states that the insurance carrier is liable for all reasonable and necessary medical costs relating to health care listed in subsection (p) only in an emergency or when "preauthorization … was approved prior to providing the health care." 134.600(p)(2) provides that non-emergency health care requiring preauthorization includes outpatient surgical services.

Review of the submitted information finds documentation to support the requestor obtained preauthorization for the disputed outpatient surgical services prior to providing the health care.

The insurance carrier's denial reasons are not supported. The disputed services will therefore be reviewed for reimbursement in accordance with division rules and fee guidelines.

3. 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 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 services. Separate reimbursement for implants was not requested.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 22551 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 5115 with OPPS Addendum A rate of $10,122.92. This is multiplied by 60% for an unadjusted labor amount of $6,073.75, which is in turn multiplied by the facility wage index of 0.9756 for an adjusted labor amount of $5,925.55. The non-labor portion is 40% of the APC rate, or $4,049.17. The cost of services does not exceed the threshold for outlier reimbursement. The sum of the labor and non-labor portions is the Medicare facility specific amount of $9,974.72. This is multiplied by 200% for a MAR of $19,949.44.
   - Payment for all other services on the bill is packaged with the primary comprehensive J1 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.

   The total recommended reimbursement for the disputed services is $19,949.44. The insurance carrier paid $0.00. The requestor is seeking reimbursement of $19,939.56. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

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 reimbursement is due. As a result, the amount ordered is $19,939.56.

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 $19,939.56, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	March 29, 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.