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 STEPHENVILLE

Respondent Name
ACE AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-19-4167-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
May 16, 2019

Response Submitted By
Constitution State Services

REQUESTOR'S POSITION SUMMARY

"Underpaid/denied APC."

RESPONDENT'S POSITION SUMMARY

"The Carrier calculated reimbursement consistent with the Medicare fee schedule and edits."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 10, 2018	Outpatient Hospital Services	$309.31	$75.61

AUTHORITY

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED
   - 4271 - PER TX LABOR CODE SEC. 413.016, PROVIDERS MUST SUBMIT BILLS TO PAYORS WITHIN 95 DAYS OF THE DATE OF SERVICE.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 1001 - Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
   - 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.
   - 947 – UPHELD. NO ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED

Issues

1. Did the health care provider timely file the medical bill with the workers' compensation insurance carrier?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with adjustment codes:
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED
   - 4271 - PER TX LABOR CODE SEC. 413.016, PROVIDERS MUST SUBMIT BILLS TO PAYORS WITHIN 95 DAYS OF THE DATE OF 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."

   Texas Labor Code §408.0272(b)(1) provides exceptions to the 95-day time limit for medical bill submission if the provider, within the period prescribed, erroneously filed 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 submitted documentation to support that the provider filed the bill initially with a group health insurance company, within the appropriate time limit, which meets the exception described above.

   Upon reconsideration, the insurance carrier did not maintain these denial reasons. Accordingly, the division concludes the health care provider timely filed the bill to the correct workers compensation insurance carrier within the time limits allowed under the Labor Code and division rules. The disputed services will therefore be reviewed for reimbursement in accordance with the division's medical fee guidelines.

2. This dispute regards outpatient facility services subject to DWC's *Hospital Facility Fee Guideline*, Rule §134.403, which requires the maximum allowable reimbursement (MAR) 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 hospital 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 L0120 has status indicator A, for services paid by fee schedule other than OPPS. If Medicare pays using other systems, Rule §134.403(h) requires use of the DWC fee guideline applicable to the code on the date provided. Per DWC *Professional Fee Guideline*, Rule §134.203(d)(1), the facility fee is based on Medicare's Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee for this code of $24.08. 125% of this amount is $30.10
   - Procedure code 99283 represents an outpatient visit assigned APC 5023. The Addendum A rate is $219.10, which is multiplied by 60% for an unadjusted labor amount of $131.46, and in turn multiplied by the facility wage index of 0.9437 for an adjusted labor amount of $124.06. The non-labor portion is 40% of the APC rate, or $87.64. The sum of the labor and non-labor portions is the Medicare facility specific amount of $211.70. This is multiplied by 200% for a MAR of $423.40.
   - Procedure codes 72125 and 70450 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. The OPPS Addendum A rate is $274.84, which is multiplied by 60% for an unadjusted labor amount of $164.90. This is in turn multiplied by the facility wage index of 0.9437 for an adjusted labor amount of $155.62. The non-labor portion is 40% of the APC rate, or $109.94. The sum of the labor and non-labor portions is the Medicare facility specific amount of $265.56. This is multiplied by 200% for a MAR of $531.12.

   The total recommended reimbursement for the disputed services is $984.62. The insurance carrier paid $909.01. The amount due is $75.61. 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 findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the division finds that additional payment is due. As a result, the amount ordered is $75.61.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, the division finds the requestor is entitled to additional reimbursement. The division hereby ORDERS the respondent to remit to the requestor $75.61, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	June 7, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). 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 field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute 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.