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 ARLINGTON

Respondent Name
FEDERAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-4190-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
May 17, 2019

Response Submitted By
No response received

REQUESTOR'S POSITION SUMMARY

"The patient's commercial insurance Blue Cross Blue Shield of Texas was initially bill on 1/21/19. It wasn't until we received the BCBS EOB on 2/21/19 that we were aware this claim was a workers' compensation claim. The initial bill was then sent to Gallagher Bassett on 3/25/19 which is 33 days from the received notification dated 2/20/19."

RESPONDENT'S POSITION SUMMARY

The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 28, 2018	Emergency Room Services	$431.02	$431.02

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. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
4. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
5. Texas Labor Code §408.0272 provides certain exceptions for untimely submission of a medical bill.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 00663 – reimbursement has been calculated according to state fee schedule guidelines.
   - 00212 – (P1) State-mandated requirement for property and casualty, see claim payment remarks code
   - Z652 - Recommendation of payment has been based on a procedure code which best describes services rendered.
   - 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.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - W3 – Request for reconsideration.
   - ZE10 – W3 – Request for reconsideration.

Issues

1. Did the insurance carrier respond to the medical fee dispute?
2. Did the requestor forfeit the right to reimbursement due to untimely submission of the medical bill?
3. Is the requestor entitled to reimbursement?

Findings

1. The Austin carrier representative for Federal Insurance Company is Downs Stanford, P.C., who acknowledged receipt of a copy of the MFDR request on May 24, 2019. Pursuant to Rule §133.307(d)(1), if the division does not receive a response within 14 calendar days of dispute notification, the division may base its decision on the available information. To date, no response has been received. Consequently, this decision is based on the information available at the time of review.
2. The insurance carrier denied disputed services with claim adjustment reason 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)(1) provides certain exceptions to the 95-day time limit for medical bill submission.
   The provider does not forfeit the right to reimbursement if the provider submits satisfactory proof that within the period prescribed by §408.027(a), the provider erroneously filed the bill with:

   (A) an insurer that issues a policy of group accident and health insurance …

   The requestor provided documentation to support meeting the exception in Labor Code §408.0272(b)(1). The requestor also provided information to support timely billing the correct workers' compensation carrier within 95 days of notification of their erroneous submission of the bill to the group health insurance company.

   Based on the submitted information, the division finds the health care provider timely sent the medical bill to the correct workers' compensation carrier within the time limits set by the Labor Code and division rules. Accordingly, the requestor has not forfeited the right to reimbursement for the service in dispute. This service will therefore be reviewed for payment in accordance with division rules and fee guidelines.
3. This dispute regards emergency room 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.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 99283 represents an emergency department visit assigned APC 5023. The OPPS Addendum A rate is $219.10. This is multiplied by 60% for an unadjusted labor amount of $131.46, and in turn multiplied by the facility wage index of 0.9736 for an adjusted labor amount of $127.99. 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 $215.63. This is multiplied by 200% for a MAR of $431.26.

   The total recommended reimbursement for the disputed services is $431.26. The insurance carrier paid $0.00. The requestor is seeking additional reimbursement of $431.02. 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 $431.02.

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 $431.02, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	August 9, 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.