TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
East Texas Medical Center

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-4448-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 10, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Proof of timely filing was attached to the appeal and Texas Mutual still denied payment."

Amount in Dispute: $724.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual has considered the erroneous billing documentation submitted which is dated 2/25/19 and concluded the 95 days from 2/25/19 would be 5/31/19. DWC 60 packet is stamped 6/10/19, therefore received past timely filing deadline."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 16, 2018	Outpatient Hospital Services	$724.98	$620.18

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 §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. 28 Texas Administrative Code §133.20 sets out the guidelines for claim submission.
4. 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

Issues

1. Did the requestor support the timely submission of the medical claim?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for outpatient hospital services rendered in February 16, 2018. Review of the submitted information found a notification dated February 25, 2019 to the health care provider that the payment originally made by United Healthcare was in error and claims should be submitted to the workers compensation carrier United Healthcare. 28 TAC 133.20 (b) states in pertinent part,

   > Except as provided in Labor Code §408.0272(b), (c) or (d), 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. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied.

   The date of notification was February 25, 2019. The date Texas Mutual audited the claim was May 23, 2019. This date is within 95 days of the notification. The insurance carrier's denial of 29 – "The time limit for filing has expired" is not supported. The services in dispute will be reviewed per applicable fee guidelines.

2. The applicable fee guideline is found in 28 TAC §134.403, (f) which states,

   > The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   >
   > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   >
   > (A) 200 percent; unless
   >
   > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

The submitted medical bill does not contain implants. The maximum allowable reimbursement is calculated as follows:

- Procedure code 73560 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is paid separately only if OPPS criteria are met.
- Procedure code 73620 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for any service assigned status indicator S, T or V. This code is paid separately only if OPPS criteria are met.
- Procedure code 99284 has status indicator of V as the criteria for comprehensive observation is not met. This code is assigned APC 5024. The OPPS Addendum A rate is $355.53, multiplied by 60% for an unadjusted labor amount of $213.32, in turn multiplied by the facility wage index of 0.787 for an adjusted labor amount of $167.88. The non-labor portion is 40% of the APC rate, or $142.21. The sum of the labor and non-labor portions is $310.09. The Medicare facility specific amount of $310.09 is multiplied by 200% for a MAR of $620.18.

- The total recommended reimbursement for the disputed services is $620.18. The insurance carrier paid $0.00. The amount due is $620.18. This amount is recommended.

3. The total recommended reimbursement for the disputed services is $620.18. The insurance carrier paid. 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 $620.18.

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 $620.18, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		July 12, 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, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

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 instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 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.