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
MIDLAND MEMORIAL HOSPITAL

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-4557-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 19, 2019

Response Submitted By
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"This is originally billed this account to BCBS as that was the information that was given at admission."

RESPONDENT'S POSITION SUMMARY

"The provider did not submit a copy of the original medical submitted to BCBS."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
September 21, 2018	Outpatient Hospital Services: CPT 76700	$216.54	$216.54

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 §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
5. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
6. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
7. Texas Labor Code §408.0272 provides certain exceptions for untimely submission of a medical bill.
8. 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.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 928 – HCP MUST SUBMIT DOCUMENTATION TO SUPPORT EXCEPTION TO TIMELY FILING OF BILL (408.0272). NOTIFICATION OF ERRONEOUS SUBMISSION NOT INCLUDED.
   - DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (800) 859-5995 X3994
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 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. 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 an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured.

   The submitted documentation supports the medical bill was timely filed electronically (and acknowledged received by the payor) with a group health insurer in accordance with Labor Code §408.0272(b)(1)(A).

   Additionally, the documentation supports the provider timely submitted the bill to the correct workers' compensation carrier within 95 days of notification of the erroneous submission of the bill.

   Consequently, 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.

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 be multiplied by 200% for these 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 76700 represents a diagnostic ultrasound, assigned APC 5522 with OPPS Addendum A rate $114.46. This is multiplied by 60% for an unadjusted labor amount of $68.68, in turn multiplied by the facility wage index of 0.9098 for an adjusted labor amount of $62.49. The non-labor portion is 40% of the APC rate, or $45.78. The sum of the labor and non-labor portions is the Medicare facility specific amount of $108.27. This is multiplied by 200% for a MAR of $216.54.

   The total recommended reimbursement for the disputed services is $216.54. The insurance carrier paid $0.00. The amount due is $216.54. This amount is recommended.

Conclusion

For the reasons above, the division finds that additional payment is due. As a result, the amount ordered is $216.54

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 $216.54, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	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.

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.