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
ETMC PITTSBURG

Respondent Name
WORTH CASUALTY COMPANY

MFDR Tracking Number
M4-19-4777-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
July 5, 2019

Response Submitted By
Salus Claims Management, LLC

REQUESTOR'S POSITION SUMMARY

"This date of service took place during the transition period for us to take over workers' compensation billing from East Texas Medical Center. I have attached a document to show that this bill was sent out on the deadline for your review and reconsideration."

RESPONDENT'S POSITION SUMMARY

"The provider did not submit verifiable proof of timely filing, therefore we are upholding the original denial for untimely filing."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
August 30, 2018	Outpatient Hospital Services	$692.86	$692.86

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired.
   - 234 – This procedure is not paid separately.
   - TC – Technical Component
   - 59 – Distinct Procedural Service
   - RN – Not paid under OPPS: services included in APC rate.
   - P14 – Payment is included in another svc/procedure occurring on same day
   - R79 – CCI; Standards of Medical/ Surgical Practice
   - 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI or workers compensation state regulations /fee schedule requirements.
   - W3 – Appeal/Reconsideration.

Issues

1. Did the provider fail to timey submit the medical bill to the insurance carrier for consideration?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 29 – "The time limit for filing has expired." The respondent asserts, "The provider did not submit verifiable proof of timely filing, therefore we are upholding the original denial for untimely filing."

   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."

   The date of service in dispute is August 30, 2018.
   The 95th day following the date of service was Monday, December 3rd, 2018.

   Review of the explanations of benefits (EOBs) submitted by both the requestor and respondent finds that the "Billed Date" indicated for the disputed medical bill is December 3, 2018. This date is *not* later than the 95th day after the date the services were provided and is within the timely submission period. Consequently, the division finds the provider timely submitted the bill to the carrier.

   Based on the submitted information, the division concludes the insurance carrier's denial reason is not supported. The disputed services will thus be reviewed for payment 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 and any outlier payment be multiplied by 200% for these 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 codes 72100 and 96372 have status indicator Q1, for STV-packaged codes. Reimbursement is included in the payment for status indicator S codes 96374 and 96375 performed on the same date of service.
   - Procedure code 96374 has status indicator S, for procedures not subject to reduction. This code is assigned APC 5693. The OPPS Addendum A rate is $191.09, which is multiplied by 60% for an unadjusted labor amount of $114.65, and in turn multiplied by the facility wage index of 0.7889 for an adjusted labor amount of $90.45. The non-labor portion is 40% of the APC rate, or $76.44. The sum of the labor and non-labor portions is the Medicare facility specific amount of $166.89. This is multiplied by 200% for a MAR of $333.78.
   - Procedure code 96375 has status indicator S, for procedures not subject to reduction. This code is assigned APC 5691. The OPPS Addendum A rate is $37.03, multiplied by 60% for an unadjusted labor amount of $22.22, in turn multiplied by the facility wage index of 0.7889 for an adjusted labor amount of $17.53. The non-labor portion is 40% of the APC rate, or $14.81. The sum of the labor and non-labor portions is the Medicare facility specific amount of $32.34. This is multiplied by 200% for a MAR of $64.68.
   - Procedure code 99285 has status indicator J2 for outpatient visits. This code is assigned APC 5025. The OPPS Addendum A rate is $520.85, which is multiplied by 60% for an unadjusted labor amount of $312.51, and in turn multiplied by the facility wage index of 0.7889 for an adjusted labor amount of $246.54. The non-labor portion is 40% of the APC rate, or $208.34. The sum of the labor and non-labor portions is the Medicare facility specific amount of $454.88. This is multiplied by 200% for a MAR of $909.76.
   - Procedure codes J2270 and J2405 have status indicator N, for packaged codes integral to the total service package with no separate payment; reimbursement is included with payment for the primary services.

   The total recommended reimbursement for the disputed services is $1,308.22. The insurance carrier paid $0.00. The requestor is seeking additional reimbursement of $692.86. 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 $692.86.

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 $692.86, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	July 26, 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.