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
ST. JOSEPH MEDICAL CENTER

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-20-0018-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 3, 2019

Response Submitted By
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"Claim was submitted to BCBS first and was denied by BCBS on 04/08/19. BCBS notified us that this was a work comp claim. Claim was then received by Texas Mutual originally on 6/17/19 (within 95 days of us being notified…."

RESPONDENT'S POSITION SUMMARY

"Audit staff denied the bill untimely as it was received beyond 95 days Rule 133.20."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 16, 2019	Outpatient Emergency Room Services	$252.01	$252.01

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 (DWC).

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 fee guideline for outpatient hospital 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:
   - 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.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (800) 859-5995 X3994.
   - 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Did the requestor forfeit the right to reimbursement due to untimely submission of the medical bill?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason 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.

   28 Texas Administrative Code §133.20(b) requires that "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 bill submission. The provider does not forfeit payment if the provider submits proof of erroneously billing (within the time limit):

   (A) … group accident and health insurance under which the injured employee is a covered insured;
   (B) a health maintenance organization that issues an evidence of coverage …
   (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment…

   Labor Code §408.0272(b)(2) also provides an exception if the failure resulted from a natural disaster or catastrophic event that substantially interfered with the normal business operations of the provider.

   The submitted information supports the provider met an exception described in Labor Code §408.0272(b)(1)(A) that the provider first erroneously billed a group accident and health insurance company that covered the injured employee. The provider was then required to submit the bill no later than the 95th day after the date the provider was notified of the erroneous submission. The notification date was April 8, 2019. Documentation supports that Texas Mutual received the bill on June 17, 2019. This date is before the 95th day following the provider's notification of erroneous filing with the group insurance. Accordingly, the division concludes that the provider has met the exception to the timely filing rule, and therefore has not forfeited the right to payment.

   The insurance carrier's denial reason is not supported. The disputed bill will thus be reviewed for payment according to DWC rules.

2. 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.

   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.

   28 TAC §134.403(f)(1) requires the Medicare facility specific amount be multiplied by 200% for these services. Reimbursement is calculated as follows:
   - Procedure codes 12002 and 90471 have status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for the visit code 99282 billed the same date.
   - Procedure code 90714 has status indicator N, for packaged codes integral to the total service package.
   - Procedure code 99282 is assigned APC 5022 with status indicator V (for outpatient visits). The OPPS Addendum A rate is $127.96. This is multiplied by 60% for an unadjusted labor amount of $76.78, and in turn multiplied by the facility wage index of 0.9754 for an adjusted labor amount of $74.89. The non-labor portion is 40% of the APC rate, or $51.18. The sum of the labor and non-labor portions is the Medicare facility specific amount of $126.07. This is multiplied by 200% for a final MAR of $252.14.

   The total recommended reimbursement for the disputed services is $252.14. The insurance carrier paid $0.00. The requestor is seeking additional reimbursement of $252.01. 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 requestor has established that payment is due. The amount ordered is $252.01.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $252.01, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	October 4, 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 28 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.