



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

ST. JOSEPH MEDICAL CENTER

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-20-0107-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

September 16, 2019

Response Submitted By

Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"Claim was originally billed to Texas Mutual on 03/26/2019 but not received by Texas Mutual."

RESPONDENT'S POSITION SUMMARY

"The provider submitted a request for reconsideration, additional documentation submitted, however it was illegible... The provider submitted the same documentation in the DWC 60 packet... It is illegible, Texas Mutual is unable to determine what the document is."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 22, 2019	Outpatient Hospital Services	\$1,656.61	\$1,656.61

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
- 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care providers.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 731 – 29 - 134.801 & 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE OF SERVICE FOR SERVICE ON OR AFTER 9/1/05.
 - 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.
 - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED
 - DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (800) 859-5995 X3994.
 - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
 - 731 – PER 133.20(B) PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE.
 - 928 – HCP MUST SUBMIT DOCUMENTATION TO SUPPORT EXCEPTION TO TIMELY FILING OF BILL (408.0272). NOTIFICATION OF ERRONEOUS SUBMISSION NOT INCLUDED.

Issues

1. Did the requester 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:

- 731 – 29 - 134.801 & 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE OF SERVICE FOR SERVICE ON OR AFTER 9/1/05.
- 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.
- 928 – HCP MUST SUBMIT DOCUMENTATION TO SUPPORT EXCEPTION TO TIMELY FILING OF BILL (408.0272). NOTIFICATION OF ERRONEOUS SUBMISSION NOT INCLUDED.

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.”

The respondent asserts, “The provider submitted a request for reconsideration, additional documentation submitted, however it was illegible... The provider submitted the same documentation in the DWC 60 packet... It is illegible, Texas Mutual is unable to determine what the document is.”

Review of the submitted document finds that the provider’s document is not illegible. It reads (in pertinent part): “Created 3/26/2019 15:30 Applied by Contributor system, Epremis ... Applied to Claim ... Institutional... Comment: Claim has Total Charges of \$21,428.87. This claim was billed to Texas Mutual Insurance.”

The submitted document is persuasive evidence of electronic claims submission to Texas Mutual Insurance Company on March 26, 2019. The date of service was March 22, 2019. The submission date is thus four days from the date of service. The dollar amount of the paper bill matches the dollar amount of the electronic bill. Based on the preponderance of the evidence, DWC finds that the health care provider has supported timely bill submission to the insurance carrier within the time period set out in 28 TAC §133.20(b). Accordingly, the division concludes the provider has not forfeited the right to reimbursement.

The insurance carrier’s denial reasons are not supported. The disputed services will therefore be reviewed for payment following DWC rules and fee guidelines.

2. This dispute regards outpatient facility services subject to DWC’s *Hospital Facility Fee Guideline*, 28 TAC §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. 28 TAC §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 codes 36415, 80053, and 85025 have status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
- Procedure codes 71260, 72128, and 74177 have status indicator Q3, for packaged codes paid through a composite APC. Codes assigned to composites are major components of a single episode of care; the hospital receives one payment for any combination of designated procedures. These services are assigned composite APC 8006, for computed tomography (CT) services including contrast. This code is assigned APC 8006 with status S. This service has an OPPS Addendum A rate of \$480.77. This is multiplied by 60% for an unadjusted labor amount of \$288.46, and in turn multiplied by the facility wage index of 0.9754 for an adjusted labor amount of \$281.36. The non-labor portion is 40% of the APC rate, or \$192.31. The sum of the labor and non-labor portions is the Medicare facility specific amount of \$473.67. This is multiplied by 200% for a MAR of \$947.34.

- Procedure code 99284 represents an outpatient visit assigned APC 5024 with status V. The OPPI Addendum A rate is \$360.37. This is multiplied by 60% for an unadjusted labor amount of \$216.22, and in turn multiplied by the facility wage index of 0.9754 for an adjusted labor amount of \$210.90. The non-labor portion is 40% of the APC rate, or \$144.15. The sum of the labor and non-labor portions is the Medicare facility specific amount of \$355.05. This is multiplied by 200% for a MAR of \$710.10.
- Procedure code Q9967 has status indicator N, for packaged codes integral to the total service package; reimbursement is included with payment for the primary services.
- Procedure code 93005 has status indicator Q1, for STV-packaged codes; reimbursement is packaged with payment for the computed tomography and evaluation and management services performed the same date.

The total recommended reimbursement for the disputed services is \$1,657.44. The insurance carrier paid \$0.00. The requestor is seeking additional reimbursement of \$1,656.61. This amount is recommended.

Conclusion

For the reasons above, the requestor has established that additional payment is due. As a result, the amount ordered is \$1,656.61.

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 \$1,656.61, 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.