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
BAYLOR MEDICAL CENTER AT UPTOWN

Respondent Name
INSURANCE COMPANY OF NORTH AMERICA

MFDR Tracking Number
M4-20-0548-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
October 25, 2019

Response Submitted By
Esis

REQUESTOR'S POSITION SUMMARY

"Please note that provider billed patient's private health insurance which copy of EOB is enclosed for review as proof of timely filing."

RESPONDENT'S POSITION SUMMARY

"The bill was received by Esis, Inc. on 6-24-19 and was denied for timely filing."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 27, 2019 to February 28, 2019	Outpatient Hospital Services	$59,246.81	$21,088.34

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) in Title 28, Part 2 of the Texas Administrative Code.

Background

1. 28 Texas Administrative Code §102.3 sets out general rules regarding due dates and time calculation.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
4. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
5. Texas Labor Code §408.0272 provides certain exceptions for untimely submission of a medical bill.
6. The insurance carrier denied payment for the services with claim adjustment reason code:
   - 29 – The time limit for filing has expired.

Issues

1. Does the response raise new defenses not presented to the requestor before the request for MFDR?
2. Was the bill timely filed with the workers' compensation carrier?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent's position statement raises new denial reasons or defenses that were not listed among the claim adjustment reason codes presented on the submitted explanations of benefits.

   28 Texas Administrative Code §133.307(d)(2)(F) requires that, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   No documentation was found to support that the respondent presented the newly raised denial reason to the requestor prior to the date that the request for medical dispute resolution was filed with DWC; therefore, the respondent has waived the right to raise such additional defenses at MFDR. Any newly raised denial reasons or defenses shall not be considered in this review.

2. The insurance carrier denied the disputed services with claim adjustment reason code 29 – "The time limit for filing has expired."

   28 Texas Administrative Code §133.20(b) requires, "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, however, allows certain exceptions to this rule. Per Labor Code §408.0272(b)(1), providers do not forfeit payment if they submit proof of erroneously billing (within the time limit) to a group accident and health insurance company or health maintenance organization (HMO) under which the injured employee is covered.

   The requestor has submitted proof of erroneously billing the injured employee's group health insurance carrier within the 95 day filing deadline from the date of service. The provider submitted an explanation of benefits (EOB) from the heath insurance company dated April 15, 2019.

   Rule 28 TAC §133.20(b) allows health care providers who meet an exception in Labor Code §408.0272 to 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.

   The provider presented convincing evidence of an email from Esis to support that March 20, 2019 was the date they were notified of erroneous bill submission to the group health insurance plan. Per Rule 28 TAC §133.20(b), the provider then had 95 days from that date to submit the bill to the correct workers' compensation carrier.

   The 95th day following March 20, 2019 was Sunday, June 23, 2019. Rule 28 TAC §102.3(a)(3) provides: "if the last day of any period is not a working day, the period is extended to include the next day that is a working day." Because the last day of the period fell on a Sunday, the filing period was extended to Monday June 24, 2019.

   The respondent states "The bill was received by Esis, Inc. on 6-24-19 and was denied for timely filing." However, the respondent's asserted date is *incorrect*. Rather, the EOB from Esis shows "Payor Receipt Date: 06/22/2019" (the 22nd not the 24th). Regardless — whether received on Saturday, June 22, 2019 or Monday, June 24, 2019 — in either case, the bill was timely received by the carrier in accordance with the Labor Code and DWC rules.

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

3. 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.

   Rule 28 TAC §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for the disputed hospital facility services, unless the provider requests separate reimbursement of implants. However, no evidence was found to support that separate reimbursement of implants was requested.

   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 28715 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure. This code is assigned APC 5115. The OPPS Addendum A rate is $10,713.88. This is multiplied by 60% for an unadjusted labor amount of $6,428.33, and in turn multiplied by facility wage index 0.9736 for an adjusted labor amount of $6,258.62. The non-labor portion is 40% of the APC rate, or $4,285.55. The cost of services does not exceed the threshold for outlier payment. The sum of the labor and non-labor portions is thus the Medicare facility specific amount of $10,544.17. This amount is multiplied by 200% for a total MAR of $21,088.34.
- Payment for all other services on the bill is packaged with the primary comprehensive J1 service per Medicare policy regarding comprehensive APCs. See *Medicare Claims Processing Manual* Chapter 4 §10.2.3 for details.

The total recommended reimbursement for the disputed services is $21,088.34. The insurance carrier paid $0.00. The amount due is $21,088.34. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of the division is to adjudicate payment following Texas laws and DWC 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 additional payment is due.
As a result, the amount ordered is $21,088.34.

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 $21,088.34, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	November 8, 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.