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
Methodist Hospital for Surgery

Respondent Name
Imperium Insurance Co

MFDR Tracking Number
M4-21-0482-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 16, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note that bill was invoiced 4/2/2020, and due to COVID-9 mailing was delay."

Amount in Dispute: $37,846.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the provider was required to submit the medical bill to the carrier no later than the 95th day following the date of service. In this case, the date of service was February 14, 2020. The 95th day following the date of service was May 19, 2020. The provider has failed to provide any documentation to support that it submitted the medical bill to the carrier o or before that date."

Response submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 14 – 15, 2020	Outpatient Hospital Services	$37,846.95	$23,308.74

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 reimbursement guidelines for outpatient hospital services.
3. Labor Code Section 408.0272(b)(2) sets out the exceptions to timely filing deadlines.
4. The insurance carrier reduced or denied the payment for the disputed services with the following claim

adjustment codes:

- 29 – The time limit for filing has expired

Issues

1. Is the requestor's position supported?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for outpatient hospital services rendered in February 2020. The insurance carrier denied the disputed services based on untimely submission of claim.

   The requestor states in their position statement, "Please note that bill was invoiced 4/2/2020, and due to COVID-19 mailing was delayed."

   The Division of Worker's Compensation Commissioner's Bulletin # B-0010-20 dated, March 25, 2020 states, "Tolling of medical billing deadlines," Failure to submit a timely medical bill will be deemed an exception due to a catastrophic event under Labor Code Section 408.0272(b)(2).

   Labor Code Section 408.0272(b)(2) states a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

   Based on the DWC Commissioner's Bulletin shown above the requestor's position is supported. Claims with dates of service 95 days prior to March 25, 2020 or December 20, 2019 and later are tolled for timely claim submission. The disputed date of service is after December 20, 2019. The insurance carrier's denial is not supported. The disputed services will be reviewed per applicable fee guidelines.

2. 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

   28 TAC 134.403 (f) states in pertinent part the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.*. The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent when a separate request for implant reimbursement is not made and 108 percent when separate reimbursement for implants is made.

   The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non-labor portion determines the Medicare specific amount. Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

   - Procedure code 22551 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 $11,900.71. This is multiplied by 60% for an unadjusted labor amount of $7,140.43, in turn multiplied by facility wage index 0.9655 for an adjusted labor amount of $6,894.09.

The non-labor portion is 40% of the APC rate, or $4,760.28. The sum of the labor and non-labor portions is $11,654.37.

The Medicare facility specific amount is $11,654.37. This is multiplied by 200% for a MAR of $23,308.74.

3. The total recommended reimbursement for the disputed services is $23,308.74. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC 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 payment is due. As a result, the amount ordered is $23,308.74.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $23,308.74, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 15, 2020 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, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

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