TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
MHHS Hermann Hospital

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-21-2228-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
August 3, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 18, 2021	Emergency Room	$3.00	$0.00
January 18, 2021	Emergency Room	$244.75	$0.00
January 18, 2021	Emergency Room	$4,183.00	Composite CT
January 18, 2021	Emergency Room	$3.525.25	$449.02
January 18, 2021	Emergency Room	$2,892.50	$728.40
	Total	$10,848.50	$1,177.42

Requestor's Position

"… per Texas Insurance Commissioner, Texas Labor Code Section 408.0272(b)(2) had been suspended due to Covid-19 Pandemic until March 1, 2021 plus 95 days. …This bill was submitted in the above mentioned timeframe. Please see the attached medical fee dispute and require the carrier to accept this as a Work-related bill and pay per Texas fee schedule."

Amount in Dispute: $10,848.50

Respondent's Position

"Our bill audit company stands on their original review. …Per TX Labor Code Sec. 408.027, providers must submit bills to payors within 95 days of the date of service."

Response Submitted by: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §133.20 sets out the requirements of timely claim submission.

3. 28 TAC §134.403 sets out the reimbursement guidelines for outpatient hospital services.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 29 – The time limit for filing claim/bill has expired
- 193 – Original payment decision is being maintained. It was determined that this claim was processed properly

Issues

1. Is the insurance carriers' denial supported?

2. What rule applies for determining reimbursement for the disputed services?

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of services rendered in an outpatient hospital setting in January 2021. The insurance carrier denied the disputed services as past timely filing. While DWC Rule 28 TAC §133.20 does require health care providers to submit the medical claim within 95 days of the date of service, exceptions are granted in Texas Labor Code §408.0272 (b) (2) when a catastrophic event interferes with normal business operations. On March 25, 2020, the Texas Department of Insurance, Division of Workers' Compensation issued Commissioner's Bulletin # B-0010-20 tolled (paused) medical billing deadlines until March 1st, 2021. The disputed date of service is prior to the end of the tolled deadline. The insurance carrier's denial is not supported. The services in dispute will be review per applicable fee guideline.

2. DWC Rule 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).

   DWC Rule 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 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 81001 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services.
   - Procedure code 72128 and 72131 have a status indicator of Q3 for packaged codes paid through a composite APC. This composite is assigned to APC 8005.

     The OPPS Addendum A rate is $224.33. This is multiplied by 60% for an unadjusted labor amount of $134.60 in turn multiplied by CBSA wage index for an adjusted labor amount of $134.88.

     The non-labor portion is 40% of the APC rate or $89.73

     The sum of the labor and non-labor portions is $224.61.

     The Medicare facility specific amount is $224.61 multiplied by 200% equals a MAR of $449.02.
   - Procedure code 99284 is subject to comprehensive packaging if 8 or more hours observation billed. This medical bill does not meet the criteria. This code is assigned APC 5024. The OPPS Addendum A rate is $363.74. This is multiplied by 60% for an unadjusted labor amount of $218.24, in turn multiplied by CBSA wage index 1.0021 for an adjusted labor amount of $218.70.

     The non-labor portion is 40% of the APC rate, or $145.50.

     The sum of the labor and non-labor portions is $364.20.

     The Medicare facility specific amount is $364.20 multiplied by 200% for a MAR of $728.40.

3. The total recommended reimbursement for the disputed services is $1,177.42. The insurance carrier paid $0.00. The amount due is $1,177.42. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement of $1,177.42 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Old Republic Insurance Co must remit to MHHS Hermann Hospital $1,177.42 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		September , 2021
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

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

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.