



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

South Texas Health System

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-17-0773-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

November 17, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is originally billed on 02/12/2016 well within the 95 day rule that applies, from the date of service. The first date of submission was via mail on 02/12/2016, which we have attached the send back letter received from the carrier on 02/11/2016 which validates that the carrier received the claim before the deadline. We then submitted the claim with the information requested and the carrier has still denied our date of service."

Amount in Dispute: \$859.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office received an initial medical bill on 6/16/2016 for dates of service 2/8/2016, 127 days from date of service. Upon completion of a clean claim review it was determined that the UB-04 was not completed and the bill was returned to the provider on 6/23/2016. A corrected bill was received on 7/16/2016 for dates of 2/8/2016... The Office researched the claim further and located the bill and records that were sent on 2/12/2016 as stated by the requestor to find that on 2/11/2016 the handling claims adjusters sent a P1 to the facility requesting the medical records and diagnostic reports to investigate and process this claim, to date the adjuster has not received these requested records."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: February 8, 2016, Outpatient Hospital Services, \$859.19, \$859.18

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 §133.240 sets out guidelines for medical payment and denials.
3. 28 Texas Administrative Code §134.403 sets out reimbursement guidelines for outpatient hospital services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 29 – The time limit for filing has expired
 - 937 – Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.

Issues

1. Did the carrier receive a timely claim?
2. What is the rule that applies to reimbursement?
3. Is the requestor due additional payment?

Findings

1. The claim is dispute is for outpatient hospital services rendered on February 8, 2016. The requestor is seeking reimbursement for \$859.19. The requestor states, “This is originally billed on 02/12/2016 well within the 95 day rule that applies, from the date of service. The first date of submission was via mail on 02/12/2016, which we have attached the send back letter received from the carrier on 02/11/2016 which validate that the carrier received the claim before the deadline.”

Review of the submitted documentation creates the following timeline:

- “P1” form from State Office of Risk Management” requesting “ER note, triage, xray reports” with date of February 11, 2016

Based on the submitted documents, the Division finds the carrier did receive a medical claim as evidenced by the carrier creating the “P1 Form” with the date of February 11, 2016.

28 Texas Administrative Code §133.240 (a) states,

An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

Therefore, as the Carrier did not submit evidence to support the requirement to “make or deny payment” within 45 days of February 11, 2016, the services in dispute will be reviewed per applicable rules and fee guidelines.

2. Outpatient hospital services are subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part,

For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

The applicable Medicare payment policy is found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

In order to calculate the correct Division fee guideline, stakeholders should be familiar with the main components in the calculation of the Medicare payment for OPSS services, which are:

- **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsh.pdf,

- *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*
- **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPSS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPSS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPSS Addenda, Addendum D1.
- **APC payment groups** - Each HCPCS code for which separate payment is made under the OPSS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

The maximum allowable reimbursement is calculated per 28 Texas Administrative Code §134.403 (f) which 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 (OPSS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

- (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 200 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

Review of the submitted medical claim finds separate reimbursement for implantables was not requested therefore, the requested services in dispute are reimbursed based on the following:

Submitted code	Status Indicator	APC	Payment Rate	Unadjusted labor amount = APC payment x 60%	Geographically adjusted labor amount = unadjusted labor amount x annual wage index 0.7989	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion)	Maximum Allowable Reimbursement
29515	S	5101	\$119.24	\$119.24 X 60% = \$71.54	\$74.54 X 0.7989 = \$57.15	\$119.24 X 40% = \$47.70	\$57.15 + \$47.70 = \$104.85	\$104.85 X 200% = \$209.70
96372	S	5692	\$42.31	\$42.31 X 60% = \$25.39	\$25.39 X 0.7989 = \$20.28	\$42.31 X 40% = \$16.92	\$20.28 + \$16.92 = \$37.20	\$37.20 X 200% = \$74.40
99284	J2	5024	\$326.99	\$326.99 X 60% = \$196.19	\$196.19 X 0.7989 = \$156.74	\$326.99 X 40% = \$130.80	\$156.74 + \$130.80 = \$287.54	\$287.54 X 200% = \$575.08
							Total	\$859.18

3. The total allowable reimbursement for the services in dispute is \$859.18. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$859.18. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$859.18.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$859.18, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

December 8, 2016

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 Texas Administrative Code §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 the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

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