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

General Information

Requestor Name
Texas Health Fort Worth

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-24-1488-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
March 11, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 3, 2023	90675	$1,432.47	$665.06
April 3, 2023	90471	$175.00	$131.12
April 3, 2023	999	$0.00	$0.00
	Total	$1,607.47	$796.18

Requestor's Position

"The Carrier should not have denied the claim because the Hospital billed the Carrier within 95 days of learning this was a workers' compensation claim after timely billing the injured employee's personal health insurance."

Amount in Dispute: $1,607.47

Respondent's Position

"It is the Respondent's belief that the Requestor did not submit documentation to support proof of timely filing on the original billing. See attached original billing and EOR… HCP submitted the original bill electronically through a Corvel Clearinghouse partner in the institutional/hospital format. Accompanying this submission was a one-page report and a statement. There was no information indicating the Requestor submitted a bill to the injured worker's group carrier. There was no copy of a group health carrier's EOR showing payment had been made to the Requestor from United Healthcare... To date, no request for reconsideration has been received by the Respondent/Carrier."

Response submitted by: CorVel

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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.20 sets out requirements of medical bill submission.
3. 28 TAC §102.4 details the general rules for Non-Division Communication.
4. Texas Labor Code 408.0272 sets out the workers compensation timely billing and exceptions guidelines.
5. 28 TAC §134.403 sets out the fee guidelines for outpatient hospital services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 29 – Time limit for filing claim/bill has expired.
- RM2 – Time limit for filing claim has expired.
- 18 – Duplicate claim/service.
- R1 – Duplicate billing.
- Note: Per Rule 133.20(b) A health care provider (HCP) shall not submit a complete medical bill later than the 95th day after the date(s) the service(s) is(are) provided.

Issues

1. Did the requestor support disputed service was originally submitted to group health plan?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for outpatient emergency room services rendered in April of 2023. The insurance carrier denied the claim based on untimely submission of the medical bill.

DWC Rule 28 TAC §133.20 (b) states in pertinent part,

(b) Except as provided in Labor Code §408.0272(b), (c) or (d), 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. (b) states in pertinent part,

(b) Notwithstanding Section 408.0272, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.0272(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

(1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:

(A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;

(B) a health maintenance organization that issues evidence of coverage under which the injured employee is a covered enrollee; or

(C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title;

(2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

A review of the submitted documentation found the following.

- Medical bill created May 17, 2023 submitted to UHC Choice / Choice Plu
- United Healthcare issued a payment to requestor, on date June 9, 2023
- Document titled “Reconsideration” dated October 23, 2023 that indicates the requestor was notified on August 7, 2023 by Adjuster that claim was to be submitted to workers’ compensation carrier.
- Explanation of Review (EOR) from CorVel indicating a medical bill for the disputed service was received on September 1, 2023.

The DWC finds the information submitted with this request for MFDR does support an exception in that the claim was originally submitted to group policy but then once notified of worker's compensation coverage, the requestor submitted a medical bill to the correct worker's compensation carrier. The insurance carrier's denial is not supported. The services in dispute will be reviewed per applicable fee guidelines.

2. The rule(s) applicable to outpatient hospital services is found at DWC Rule 28 TAC §134.403 (d) which 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 (e)(2) states in pertinent part, regardless of billed amount, if no contracted fee schedule exits that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

   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 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 bill found implants are not applicable. The Medicare facility specific reimbursement amount will be multiplied by 200 percent.

   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 90675 has status indicator K, for nonpass-through drugs and biologicals separately paid by APC. This code is assigned APC 9139. The OPPS Addendum A rate is $342.22 multiplied by 60% for an unadjusted labor amount of $205.33, in turn multiplied by facility wage index 0.9528 for an adjusted labor amount of $195.64.

The non-labor portion is 40% of the APC rate, or $136.89.

The sum of the labor and non-labor portions is $332.53.

The Medicare facility specific amount is $332.53 multiplied by 200% for a MAR of $665.06.

- Procedure code 90471 has status indicator Q1, for STV-packaged codes; reimbursement is included with payment for any other service assigned status S, T or V—not separately paid unless no such services are billed. This code is assigned APC 5692. The OPPS Addendum A rate is $67.47 multiplied by 60% for an unadjusted labor amount of $40.48, in turn multiplied by facility wage index 0.9528 for an adjusted labor amount of $38.57.

  The non-labor portion is 40% of the APC rate, or $26.99

  The Medicare facility specific amount is $65.56. multiplied by 200% for a MAR of $131.12.

3. The total recommended reimbursement for the disputed services is $796.18. The insurance carrier paid $0.00. The amount due is $796.18. 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 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 Indemnity Insurance Co of North America must remit to Texas Health Fort Worth $796.18 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 26, 2024 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.